Division of STATISTICAL RESI	MARYLAND STATE DEP EARCH AND RECORDS, 301			LAND 21201
× 00070	CERTIFICATE	OF DEATH		00070
1. PLACE OF DEATH 0. COUNTAnne Arundel	MARYLAND	2. USUAL RESIDENCE (W o. STATE Maryl	there deceosed lived, if institute and b. COUI	ion: Residence before odmission) NTY Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, North Arundel Hospital	c. LENGTH OF STAY IN 1b	Gambrills d. STREET ADDRESS Box 133,		RAL and give neorest town) e. IS RESIDENCE ON A FARM? YES NO XX
3. NAME OF DECEASED (Type or print) Herbert Thom		Lost	4. DATE Mont OF January	th Doy Year
S. SEX 6. COLOR OR RACE WIDOWED WIDOWED	The state of the s	2-26-99	9. AGE (In years lost birthday)	Months Doys Hours Min.
during most of working life, even if retired)	KIND OF BUSINESS OR INDUSTRY Onstruction	Cleveland	State, or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME James Thomas Allen		14. MOTHER'S MAIDEN N	ame ce May Knott	
(Yes, no, or unknown) (If yes give war or dates of service)	563-22-1655 Mrs.	trom 6		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING				19. WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH	DESCRIBE HOW INJURY OCCURRED. (E			
Hour o.m. 19 While at wo	le Not While focto	E OF INJURY (Home, form, ory, street, office bldg., etc.)	70	(County) (State)
21. I certify that (I) (this hospital) offer saw the deceased alive on 220. SIGNATURE	nded the deceased from		AM, from couses	ond an the date stated above 22b_DATE SIGNED
220. SIGNATURE	triale, MD.	. PHYS A	MED. STAFF DIRECTOR PHYS.	Jon 25, 1967
/ 22c PHYSICIAN'S Dr. Joseph Tale	r	95 Aquahar	rt Road, Glen	Burnie, Md

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00071 requires that the death certificate be executed within 24 haurs after death and funeral I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY filled in by the fun papers. Pages 1 c Maryland Anne Arundel Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Shady Side Annapolis davs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? filled i Anne Armndel General Hospital Nowell Road NO. YES carban 3. NAME OF First Middle DATE Last Month Day Year DECEASED ATWELL William 19 67 (Type or print) Francis DEATH January 16 IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS 7. MARRIED XX NEVER MARRIED birthdoy) Months Days Hours Oct. 18, 1885 Male White WIDOWED DIVOR CED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY U.S. Maryland BUILDING CONTRACTOR 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, ar removal, 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) ond (c).) INTERVAL BETWEEN signed by the burial-transit burial, cremati PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) be retained by the haspital ar attending physician DUE TO cocclerosis Conditions, if ony, which gove rise to immediate cause (a). DUE TO stating the underlying couse prior ta PHYSICIAN: The law lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) detached far use te Dept. af Health YES NOXIX **DIRECTOR:** After this certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour 'o.m. factory, street, office bldg., etc.) Not While of work Jan. 16, 19 6 that (1) box last 21 - certify that (I) (this characted) attended the deceased fram. . 19. . ta 19 67, and that death accurred at the deceased alive on Jan M, fram causes and an the date stated above 22b. DATE SIGNED STAFF M.D. DIRECTOR PHYS. director, page should be filed 22d. ADDRESS O FUNERAL NAME (Type) Willard F. Smith. M.D. Shady Side. Md. 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Jown) (Stote) REMOVAL (Specify) DURING 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR

Is very sent article 2 2 0 194 alib en tend from on Easter M. German't for more source. 197.(2)/ --- 10.53 a tour 5. Japa' yta' 1 hemia Nepproceers of prolitic T beniff

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral death. and death PLACE OF DEATH 1. 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY by the f Pages 1 urs after 24 hours after MARYLAND b. CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give mearest town) ve carbon papers. Pag event, within 72 hours E filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS within etely NAME OF Middle DATE Month Last DECEASED comple DEATH (Type or print) executed 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED гетоуе NEVER MARRIED last birthday) AUB and WIDOWED DIVORCED physician a = 10a. USUAL OCCUPATION (Give kind of work done during most/of working life, even if retired) 10b. KIND OF BUSINESS OR HPLACE (County & State, or foreign country) ease Pe and INDUSTRY certificate 13. FATHER'S NAME . removal. MOTHER'S MAIDEN NAME ing ph Then attendin 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. 5 (Yes, no, or unkown) ((If yes gife war or dates of service) Teath cremation. the 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) been signed by the burial-transit or to burial, crema PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a) **DUE TO** requires Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the as th underlying cause last. aw. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health p r this certificate I detached for use te Dept. of Health hospital or PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of Item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) factory, street, office bldg., etc.) be de State Hour a.m. Not While After While at work at work p.m. retained should ith the S 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should filed with the .M. from the causes and on the date stated above. saw the deceased alive on. and that death occurred at. age 4 ...
FUNERAL Di. 22a. SIGNATURE OR be ATTENDING PHYS. STAFF DIRECTOR TO HOSPITAL PHYSICIAN'S ADDRESS 22c. 22d. NAMB (Type) BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR 23d.

22b. DATE, SIGNED director, p LOCATION (City, town or county) (State) 2 REMOVAL (Spacify) 2000 md CY ricu DGK 25b. REGISTRAR'S SIGNATURE 24. **FUNERAL DIRECTOR ADDRESS** 25a. REC'D BY REGISTRAR VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

IS RESIDENCE

ON A FARM? NO X

Year

19

Hours

INTERVAL BETWEEN

ONSET AND DEATH

WAS AUTOPSY

PERFORMED?

that (I) (we) last

NO -

(State)

YES

(County)

YES

Months

Days

12. CITIZEN OF WHAT

COUNTRYS

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00073 deoth. **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 haurs after death, by the funeral Poges 1 and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel Maryland nd completely filled in by the fur emove corbon papers. Pages 1 ony event, within 72 hours after MARYLAND Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside carporate limits, write RURAL and give negrest tawn) c. LENGTH OF STAY IN 16 Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Anne Arundel General Hospital 179 West Street YES NO PO 3. NAME OF remove corbon 4. DATE Last Month Day Year DECEASED (Type or print) da Louise BIAS DEATH January 19 67 9. AGE (In years S. SEX IF UNDER 1 YEAR 6. COLOR OR RACE 8. DATE OF BIRTH **IF LINDER 24 HRS** 7. MARRIED NEVER MARRIED last birthdoy) Months Hours WIDOWED DIVORCED December 23,1900 Female Negro 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even it retired) INDUSTRY COUNTRY? Annapolis, Maryland U. S. EATHER'S NAME 14 MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) If If yes give wor or dates of service) 18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).) NTERVAL BETWEEN signed by the buriol-transit p PART I DEATH WAS CAUSED BY **QNSET AND DEATH** IMMEDIATE CAUSE (o) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital or attending physician. DUE TO buriol. Canditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? NO this certificate 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Horne, form, (City or town) (County) (State) Hour 'o.m. Nat While foctory, street, office bldg., etc.) 21. I certify that (1) (this haspital) attended the deceased fram. ____, that (I) (we) last sow the deceased alive on_ from couses and an the date stated above. and that death occurred 220. SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. 22d. ADDRESS 22c PHYSICIAN'S ALLE FUNERAL NAME (Type) 230. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) (Stote) (County) REMOVAL (Specify) 0 2So. REC'D BY REGISTRAR FUNERAL DIRECTOR ADDRESS 25b.

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TO HOSPITAL OR may be retained TO FUNERAL DIR

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3. NAME OF DECEASED MARY PROBLEM AND PROPERLY AND PROPERL	00074		CERTIFICA'	TE OF DEATH		00074
RURAL ond give necretal bown! Greenland Beach d. NAME OF HOSPITAL (if not in hospito) give street oddress) d. STREET ADDRESS (a. STREET ADDRESS (b. STREET ADDRESS (c. STREET ADDRESS (c. STREET ADDRESS (d. STREET ADDRES	- COUNTY	ne Arundel	MARYLAND	2. USUAL RESIDENCE (W	here deceased lived. If institut and b. COUNTY	
Greenland Beach	b. CITY OR TOWN	(If outside corporate limits, write	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporate limits, write l	RURAL and give nearest town)
d. STREET ADDRESS 1111 Greenland Beach Road 112 Greenland Beach Rd. 113 Greenland Beach Rd. 113 Greenland Beach Rd. 114 Greenland Beach Rd. 115 Greenland Beach Rd. 115 Greenland Beach Rd. 116 Greenland Beach Rd. 117 Greenland Beach Rd. 118 Greenland Beach Rd. 119 Greenland Beach Rd. 119 Greenland Beach Rd. 119 Greenland Beach Rd. 119 Greenland Beach Rd. 110 Greenland Beach Rd. 110 Greenland Beach Rd. 110 Greenland Beach Rd. 110 Greenland Beach Rd. 111 Greenland Beach Rd. 111 Greenland Beach Rd. 112 Greenland Beach Rd. 113 Greenland Beach Rd. 114 Greenland Beach Rd. 115 Greenland Beach Rd. 115 Greenland Beach Rd. 116 Greenland Beach Rd. 117 Greenland Beach Rd. 118 Greenland Beach Rd. 119 Greenland Beach Rd. 119 Greenland Beach Rd. 119 Greenland Beach Rd. 110 Greenland Beach Rd.			h yrs.	Greenl	land Beach	12.1
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Discrepance	114 Gree	enland Beach Roa	d	1114 Gree	enland Beach Ro	ON A FARM? YES NO
Pemale White WIDOWED DIVORCED March 14, 1900 Go yrd Months Doyr Hours March 14, 1900 Go yrd G	DECEASED				OF -	
DIVIDITED MIDOWED DIVIDICED March 11, 1900 66 yr.	5. SEX	6. COLOR OR RACE 7. MARI	RIED NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years	
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HOUSEWIFE 13. FATHER'S NAME Claude Hunley 15. WAS DECEASED EVER IN U. S. ARMED FORCES? I 16. SOCIAL SECURITY NO. IV. INFORMANT NO 16. PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) IV. WAS AUTO FERFORMET. IV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) IV. WAS AUTO FERFORMET. IV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) IV. WAS AUTO FERFORMET. IV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) IV. WAS AUTO FERFORMET. IV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) IV. WAS AUTO FERFORMET. IV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) IV. WAS AUTO FERFORMET. IV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) IV. WAS AUTO FERFORMET. IV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) IV. WAS AUTO FERFORMET. IV. OTHER III.	10a. USUAL OCCUPATI	ON (Give kind of work done 10b.	KIND OF BUSINESS OR INDUS	TRY 11. BIRTHPLACE (Stote	or foreign country)	12. CITIZEN OF WHAT COUNTRY
S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 16. SOCIAL SECURITY NO. 17. INFORMANT Address 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Virginia Reed Same INTERVAL BETWEE ONSET AND DEA	Housewif	e	None	Virgini	a	U. S.
18. CAUSE OF DEATH Enter only one course per line for (c). (b). and (c).	13. FATHER'S NAME			14. MOTHER'S MAIDEN	NAME	
Test Course of Death Enter only one couse per line for (o), (b), and (c).	Chaude	Hunley		Lola B.	Taylor	
No Mrs. Virginia Reed Same	15. WAS DECEASED EV		SOCIAL SECURITY NO. 17. IN	FORMANT	Add	dress
PART II. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate couse (b). In all NUTRITION DUE TO Conditions, if any, which gove rise to immediate couse (c). Intermediate co	No	for her dive not an error or services	Mrs	s. Virginia	Reed Same	
DUE TO Conditions, if any, which gove rise to immediate couse (a), storing the under couse (a), storin	1B. CAUSE OF DE	ATH [Enter only one couse per li	ne for (o), (b), and (c).]			INTERVAL BETWEEN
Conditions, if any, which gove rise to immediate couse (c), toting the underlying couse lost. Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOF PERFORMED TO ACCIDENT WAS UNDERLYING TO ACCONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINES) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED, (Enter noture of injury in Port or Part IVof item 18.) 21. I certify that (1) (Abit of work	PART I. DE.	ATH WAS CAUSED BY:	The second second			ONSET AND DEATH
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saw the deceased alive an 1/2 1967, and that death occurred a 2.M, from the causes and an the date stated above 220. SIGNATURE 220. SIGNATURE Each M.D. ATTENDING MED. DIRECTOR STAFF PHYS. 220. DATE CONTROL 230. DATE THEREOF PHYS. 220. ADDRESS 220. ADDRESS 220. ADDRESS 220. ADDRESS 230. LOCATION (City, town, or county) (Stote) Buffal (Specify) Jan. 5, 1967 Woodlawn Cemetery Bluefield, West Virginia 24. FUNERAL DIRECTOR'S GIGNATURE 250. REGISTRAK'S SIGNATURE 260. REC'D BY REGISTRAK 250. REC	ZOc. TIME OF INJUI	RY Month, Doy, Year 20d. II White	Not while foc			(County) (Stat
220. SIGNATURE Eacl Will M.D. PHYS. DIRECTOR STAFF PHYS. DIRECTOR PHYS. DIRECTO			100	eath accurred 7 35	263, ta 1/2 M. from the causes a	nd an the date stated above
Riviera Beach, Maryland 230. BURIAL CREMATION, PREMOVAL (Specify) Burial Specify Jan. 5, 1967 Woodlawn Cemetery ADDRESS ADDRESS ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE ADDRESS ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE		C. Earl	4:10	ATTENDING . A	AED STAFF	22b. DATE SIGNE
Burial (Specify) Jan. 5. 1967 Woodlawn Cemetery Bluefield, West Virginia 24. FUNERAL DIRECTOR'S GIGNATURE ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE		C. Earl Hill			era Beach, Mar	ryland
1.007 Petable Hay Dalta IAN 9 1007 Pelando Oute	Burial (Specify	Jan. 5, 1967	Woodlawn Cer		Bluefield, We	est Virginia
George/J. Gonce Md.	George	I Sonce 4		Balto. DATE J	17	2501 0

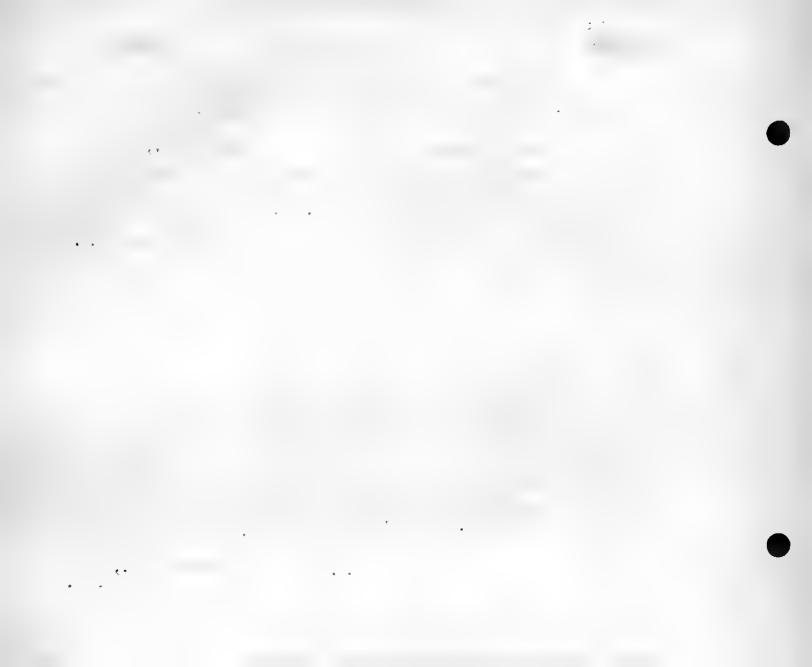
60026 AT000 * - 10 E095 0.5055-As a real scale of the Control of th Mile and the second of the sec Section 1 was the last all the the second ASSESSMENT OF THE PROPERTY OF THE PARTY OF T

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. 2 LISUAL RESIDENCE/Warre deceased I ved. If institution Residence before admission PLACE OF DEATH o COUNTY o STATE b COUNTY 3 to PM3. Page Department of death. MARYLAND c CITY OR-JOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN NO b_C.IY_OR TOWN (If outside corporate .mits. and after e IS RESIDENCE ON A FARM? g ve street address) d STREET ADDRESS word "pending" in pencil in Item 18 Give Pages 1, the Chief Medical Examiner's Office along with form hours Give Pages 1, Strept YES NO X Stote | 24 hours ofter death Midd e DATE Month Doy NAME OF Yeor DECEASED the 196 DEATH with the (Type or print) 9 AGE (In veors IF LINDER YEAR IF LINDER 24 HRS 5 SEX 7 MARRIED NEVER MARRIED airthdoy) Months Dovs Hours in Item 18 DIVORCED WIDOWED event ond 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 10a JSUAL OCCUPAT ON (Give kind of work done COUNTRY? during roost of working life, even prefired) Houseur 14 MOTHER & MAIDEN NAME 13 FATHER/S NAM certificate should be executed within 16. SOCIAL SECURITY NO INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? unknown) (fives give wor or dates of service NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o) (b) 2004 (c). SET AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY 0 IMMEDIATE CAUSE (o' writing the word cremation, DUE TO Conditions, if ony, which gove (b) 2 rise to immediate couse (a). DUE TO stating the underlying couse В lost. 00 burial nsed 19. WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART I(o) PERFORMED ő YES the certificate. 0 þe 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port L or Port 1) of item 18) prior 3 should PRIMARY OF CONTRIBUTING AL EXAMINER: CAUSE OF DEATH ogent, | MEDICAL 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month Day, Year 20d NIURY OCCURRED foctory street, office bldg. etc.) Hour am. While Not White FUNERAL DIRECTOR: Poge at work please execute designated 21. I certify that took marge of the remains described above, held an Autopsy [and in my apinion Inspection inquiry ū Suicide Undetermined manner deoth resulted from: Notural couses Accident Homiade the funeral director be retained CHIEF MEDICAL EXAMINER 22. DATE SIGNED **ACTUAL** ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER 10 **EXAMINER'S** Address (Street, city, town, or county) Heolth NAME (Type) NAME OF CEMETERY OR DATE THEREOF LEICATION (City or Town) 9.0 256 REGISTRAR 24 FLINERAL DIRECTOR VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



1 .			DIVISION			ID STATE DEP 301 W. PREST				RYLAND 2	21201			
	00	076				CERTIFICATI	OF D	EATH			000	76.		
,	1 PLACE (OF DEATH ITY	Anne Arui			MARYLAND	a. STATE	Ma	rylar		b. COUNTY	Anne	Arur	ndel
ly event, wintin 22 nouts uney bear		Anna	f autside carporate limit give nearest town) polis			H OF STAY IN 16	c CITY OR		inapo]	arate limits, v Lis	vrite RURA	L and give ne	100	1
	d. NAM	OF HOSPit	AL OR INSTITUTION (If no	ot in hospital,	give street (oddress)	d STREET						e IS	RESIDENCE A FARM?
7			del_General		tal_					ment S				иожх
	3 NAME DECEAS (Type of	ED	Willia	rst Lang	Hen	Middle ry	BROWN		4. DATE OF DEAT	rh Ja	Month anuar	У	Doy 5	Year 19 67
	s sex	6	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEV	ER MARRIED DIVORCED	B. DATE OF E		198	9. AGE (In last birth	yeors ndoy) yrs.	IF UNDER 1 YE Months Do		urs Min.
	10a USUAL during mos	OCCUPATION totworking	(Give kind of work done ite, even (Fetired)	10b. K	IND OF BUS	INESS OR				foreign countr	y) yland	12 CITIZE	N OF WH.	AT
	IS. WAS D (Yes, no, or Ln Cun	unknown)	R IN U.S ARMED FORCES? (If yes give wor ar doles of ATH (Enier only one cou H WAS CAUSED BY IMMEDIATE CAUSE	If service)	SOCIAL SECTION (o), (b), or	(d)	HORMANT	RS MAIDEN	100	M.	Address 7 M	rence		PETWEEN ND DEATH
	Condition rise to storing lost.	ions, if ony, immediat	which gove e couse (a), lying couse	TO (b) A =	Larin	se levatil	1					J	ri	,
	NOIL		SNIFICANT CONDITIONS C			UT NOT RELATED TO Lycardist V INJURY OCCURRED							19. WAS PERF YES	ORMED?
	OR CO	NTRIBUTING	JNDERLYING □ □ CAUSE OF DEATH MEDICAL EXAMINER)											
	WED	n.e ruoH rg	n. 19	While at wor	k 🔲 at v	While 🔲 💮 for	ACE OF INJURY tory, street, af	fice bldg., etc	.)	. 0-		(County		(State)
	50	w the di	y that (I) (166266) eceased otive an_	Jan	ded the d	deceased from 9 <u>67</u> , and the	it deoth oc	curred of	9:30	_M, fram c	ードゥ グ Ouses Of	nd an the	date st	I) (2424) last oted obove.
		SIGNATURE 1204	et Br	en-		М		NG	MED DIRECTOR	IATZ STAI	S.	22b. DATE :	SIGNED /	
/		PHYSICIAN S NAME (Type)				iern, M.I		DDRESS 1	1 /2		mapo	lis, N		
	REMO	AL, CREMATIC DYAL (Specify	al 1-9-	1967	23c. NA	ME OF CEMETERY OF	REMATORY 1	(A)	D BY REGI	COLUMN (CI	reck	STRAR'S SIGN	Onty)	15100
7	11/1	RAL DIRECTO	amik	les	ett.	S File	all the	DATE J	. 4	0 1967	ZOU, KEGI	MENT S SIGN	es ye	edge



	DIVISION OF STATISTICAL RESE		, 301 W. PRESTON	STREET, BALTIMORE	
-	PLACE OF DEATH	CERTIFICAT	E OF DEATH		0077
1.	a. COUNTY			(Where deceased lived, 11 institu	
_	ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits	MARYLAND c. LENGTH OF STAY IN 1b	a. STATE MARYLAN	D ANNE A	RUNDEL
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	1 Hr.	ANNAPOLIS		KONYE BIIG BIAG HESTEST TOWN
_	ANNAPOLTS d. NAME OF HOSPITAL OR INSTITUTION (if not in I		d. STREET ADDRESS)	e. IS RESIDENCE
	NAVAL HOSPITAL		NAVAL HOS	PITAL	ON A FARM?
3.	DECEASED	Middle	Last	4. DATE Month	Day Year
	(Type or print) JOSEPHINE		ALDWELL	DEATH JANUARY	13 1967
	7. MARKIEL	INEVER MARKIEDA	B. DATE OF BIRTH	last birthday) Mo	UNDER I YEAR IF UNDER 24 HR nths Days Hours Min.
	emale CAUC WIDOWEL B. USUAL OCCUPATION (Give kind of work done 10b.	DIVORCED 1	S - Contract of the	67 yrs. [nty & State, or foreign country)	12. CITIZEN OF WHAT
dui		INDUSTRY		el. Maryland	12. CITIZEN OF WHAT COUNTRY?
13	. FATHER'S NAME		14. MOTHER'S MAIDE		0.5.
	JAMES CALHWELL		MARGARET M	ARY ANDERSON	
15 (Ye		SOCIAL SECURITY NO. 17.	INFORMANT	Address	
			Hospit	AL KECORS	75
	18. CAUSE OF DEATH [Enter only one cause per	line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY:	ematurch	\		1 hour
	Conditions, if any, which)				
	gave rise to immediate (
	cause (a), stating the DUE TO underlying cause last. (c)				
NOI	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB	UTING TO DEATH BUT NOT RELA	TED TO THE TERM INAL DI	SEASE CONDITION GIVEN IN PAR	TTI(a) 19. WAS AUTOPSY PERFORMED?
ICAI					YES X NO
CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 1 20b. OR CONTRIBUTING 1 CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCU	RRED. (Enter nature of i	njury in Part I or Part II of it	em 18.)
MEDICAL	Harris & Har	facto	CE OF INJURY (Home, farrry, street, office bldg., etc	n, 20f. (City or town)	(County) (State)
M	p.m. 19 at wor	mor writte — :	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	21. I certify that (1) (this hospital) attend	ded the deceased from_1.	3 JAN, <u>1</u> 5	7 to 13 JAN ,	19 67, that (I) (we) fas
	saw the deceased alive on 13 JAIN 22a, SIGNATURE	19 67 and that	death occurred at	M, from the causes and	on the date stated above Date Signed
	Alan Don	M.D.	ATTENDING MI		13 JAN 1967
	22c. PHYSICIAN'S	The mile	22d. ADDRESS	RECOUR L. PRIS. 451	
	NAME (Type) C. L. GAUDRY, 1	LT'MC USN	NAVAL HOSP	ITAL, ANNAPOLIS	, MD.
235	BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City, town	or county) (State)
¥4	JURITH 1-16-67	ADDRESS ACT	DEMY	D BY REGISTRAR 250. REGIS	STRAR'S SIGNATURE
24	Mr. In toulers mes	Smaphin	New That	1 8 1007 Mile	arles Judge
7	1 millitaries son	July ws	DATE AN	10 10011	0
	-				



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00078 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death campletely filled in by the funeral save carbon papers. Pages 1 and y event, within 72 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY AFIRE ATUNCE!

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND Maryland Anne Arundal
c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b Glen Aufnie Pasadena d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENC ON A FARM? N. Arundel Hospital YES | NO F 323 Hickory Point Rd the attending physical and completely fi sit permit. Then please remave carbon 3. NAME OF Middle 4. DATE First Doy Year DECEASED OF DEATH Type or print CARMELO FRANK CATALIT January AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Davs Haurs Male Unite WIDOWED DIVORCED March 8.1921 10o US. IAL OCC JPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHA! during mast of working ite, even if retired) COUNTRY? INDUSTRY Used Car Dealer(Ret Self Maryland Fmoolved LICA 14 MOTHER'S MAIDEN NAME or remaval Anthony Cataldi Mary Russo INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 14. SOCIAL SECURITY NO Address (Yes, no, grunknawn) (If yes give wor ar dates of service) Mes 214-18-6359 Same as 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. IO FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying couse detached for use as the te Dept. of Health priar to last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? CERTIFICATION mane YES NO 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (Stote) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) foctory, street, office bldg., etc.) Nat While ot wark at work 21. I certify that (1) (this-hespital) attended the deceased from... , 1958, 10. . 196 L. that (I) (we) last 19 6 Z, and that death accurred at 1 BM, from causes and an the date stated above. saw the deceased alive an. 22b DATE SIGNED 22a. SIGNATURE DIRECTOR director, page 3 should be filed v M.D. 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City or Town) *23c NAME OF CEMETERY OR CREMATORY (County) (State) 23o. BURIAL CREMATION. 23b. DATE THEREOF REMOVAL (Specify) "arvland Glen Burnie. Glen Haven Mem. Park Buria. 2Sb. REGISTRAR'S SIGNATURE 25a, REC'D BY REGISTRAR MERAL MRECTOR Singleton Funeral VR A15 (4) 20 M 1/66 Glan Burnie, Md



		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
E TAI		00079 CERTIFICATE OF DEATH 00080
funeral funeral	1.	PLACE OF DEATH a. GDUNTY 2. USUAL RESIDENCE (Where deceased lived, 11 institution: Residence before admission)
24 hours after death. filled in by the funeral papers. Pages 1 and 2 him 72 hours after death		MARYLAND MARYLAND B. COUNTY A - CO.
by the 1 Bages 1 Urs after		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arite RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. GITY OR TOWN (if obtside corporate limits, write RURAL and give nearest town)
d in Cr.	7	Achier than I will be a second of the second
n 24 y fille paper hin 72		10 2 Box 699 -St-) Westin Land DC > Box 699 YES NO D'
executed within 24 hours at and completely filled in by t remove carbon papers. Page n any event, within 72 hours a	3.	NAME DF First Middle Lest 4. DATE Month Day Year OFFICEASED (Type or print) ELIZA'BETH CILICK DEATH 1967
com	5.	SEX 6. GOLOR OR RAGE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 ARS.
and remo		1-E11 RIFE WIDOWED DIVORGED 3-15-33 WI VIS.
s be s sician ease l and in	du	a. USUAL OCCUPATION (Give kind of work done Industry) 12. CITIZEN DF WHAT COUNTRY? 13. CITIZEN DF WHAT COUNTRY?
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execulaged 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and director, page 3 should be detached for use as the burial-transit permit. Then please removable tiled with the State Dept. of Health prior to burial, cremation, or removal, and in any	13	FATHER'S NAME KALINCSAK 14. MOTHER'S MAIDEN NAME
2 1 2 1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	T. (Y	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SEGURITY NO. 17. INFORMANT Address es, no, or unknown) (If yes give war or dates of service)
deat le at perm ion,	L	AID - MARGARET BENSINGER - ABOUTE
the y th usit		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS GAUSED BY: Tipogargoma loft supra-classical are area.
hat ician led l l-trai		IMMEDIATE CAUSE (a) HIPOSAICOIRA, TELE SUPLA-CIAVICULAL ALEA 5 mo.
othys sign uria uuria		Genditions, If any, which (b)
ing ling l		gave rise to Immediate (cause (a), stating the DUE TD
aw r tend las k as t as t prior	Įz	underlying cause last, (c)
The Land cate It are a cate It	CERTIFICATION	PART II. OTHER SIGNIFIGANT GONDITIONS GONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED X YES NO
certification of H	1	20a. AGGIDENT WAS UNDERLYING 20b. DESGRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part or Part of Item 18.) OR CONTRIBUTING GAUSE OF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER)
PHYS the the detailed	MBOICAL	2Dc. TIME OF INJURY Month, Day, Year 20d. INJURY OGGURRED 20e. PLACE OF INJURY (Home, farm, 1 20f. (City or town) (Gounty) (State) Hour a.m. While Not While Not While 1 factory, street, office bidg., etc.)
d by After	Ξ	p.m. 19 at work []
TENT aine OR: hould		21. I certify that (I) (this hospital) attended the deceased from Aug., 19.57, to Jan., 19.67, that (I) (we) last saw the deceased aliye on Dec., 19.66, and that death occurred a 9.30.2M, from the gauses and on the date stated above.
AT AT SECTION WITH WITH		22a. SIGNATURE
ay be	1	ATTENDING M.D. ATTENDING MED. STAFF 1-2-67
SPITA e 4 mis NERAL ctor, p		PHYSIGIAN'S Francis I. Codd M.D. 22d. ADDRESS Severna Park, Maryland
Page Page O FU direct	23	REMOVAL (Specify)
0	2/	K FUNERAL DIRECTOR ADDRESS 25a. REGISTRAR'S SIGNATURE
VR AJ5 (4)	200	Charl S. Lerrance, Severna Ph. M. Charte 4 1837 " Judge
20M 1/03 3	A	ERIELS, BARRONCE



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 18000 CERTIFICATE OF DEATH death requires that the death certificate be executed within 24 hours after death and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fived, if institution: Residence before admission) completely filled in by the funeral layer carban papers. Pages 1 and o COUNTY o. STATE **b** COUNTY Anne Arundel
b CITY OR TOWN (if autside carparate limits,
write RURAL and give neorest town) Marvland MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 3 vears Baltimore Grownsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS Crownsville State Hospital 607 Pennsylvania Ave. YES NO V 3 NAME OF DECEASED Middle 4 DATE Last Year OF DEATH #26249 George Colbert 5 1967 (Type or print) S. SEX 6 COLOR OR RACE 7 MARRIED B. DATE OF BIRTH 9 AGE (in years IF JNDER I YEAR IF UNDER 24 HRS NEVER MARRIED birthday) Male Negro 4/12/1912 WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12 CITIZEN OF WHAT 10b, K NO OF BUSINESS OR 11. BIRTHPLACE (County & Stote or foreig country) COUNTRY? Unknown
13. FATHER'S NAME Maryland
14. MOTHER'S MAIDEN NAME LISA Unknown Unknown 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, ar unknown) (If yes give war ar dates of service) 16 SOCIAL SECURITY NO 17 INFORMANT Address Unk. Hospital Records Unk. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN signed by the burial-transit ONSET AND DEATH Bronchopneumonia IMMEDIATE CAUSE (a). DUE TO Canditions, if any, which gave rise to immediate cause (o), DUE TO stating the underlying cause as the TO FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? director, page 3 should be detached for use should be filed with the State Dept. of Health Chronic Brain Syndrome due to Convulsive Disorder (Epilepsy) NO X 20g ACCIDENT WAS UNDERLYING [7] 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (Stote) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg , etc.) Not While at work at wark 21. I certify that (I) (this haspital) attended the deceased fram. 10/18/, 19 63, to 1/5/ _, 1967, that (I) (we) last 1967., and that death accurred a 8: 48 M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a, SIGNATURE X 1/5/67 M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Crownsville State Hospital, Md. L. Benedict. 23a BURIAL, CREMATION, REMOVAL (Specify) 24. FUNERAL DIRECTOR 28b. DATE THEREOF 25b. REGISTRAR S SIGNATURE 2So. REC'D BY REGISTRAR VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH



, 1	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE	0008 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 0008	2
HEALTH DEPT		Arundel
hours ofter death If why delay is fem 18. G ve Pages 1, 2, and 3 to Office along with form PM3. Page and 2 with the State Department of death.	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearly town) C LENGTH OF STAY IN 1b C CITY OR TOWN (If outside corporate mits, write RURAL and give nearly town) Glen Burnie	
まご 島 る ベス/・	d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street oddress) North Arundel General Hospital 1529 Ingalls Rd.	e IS RESIDENCE ON A FARM? YES NO
hours offer death tf of tem 18. G ve Pages 1, Office along with form and 2 with the State Dei death.	(Type or pnot) WILLIAM ATWELL CRAWFORD OF DEATH 1 1	
ours ofte em 18. G ffice olor ind2 with deoth.	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years lost birthdoy) 39 yrs Months Doy 39 yrs	ys Hours Min
		OF WHAT
encil mine	JOSEPH P. CRAWFORD, SR. 14. MOTHER'S MAIDEN NAME CLARA KIMBREW	
INER: This certificate should be executed within 24 hours after death the certificate, writing the word "pending" in pencil in Item 18. Give Pages should be farwarded to the Chief Medical Examiner's Office along with for files. 3 should be used as a bunol-transit permit, File offices, and 2 with the State tion, or removal, and in any event within 72 hours at it death.	15 WAS DECEASED EVER IN US ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) YES 16 SOCIAL SECURITY NO 17 INFORMANT MARY E. CRAWFORD GLEN BURNIE, MD.	
should be executed to word "pending" in to the Chief Medical Exburiol-transit permit. Find any event within 72 in any event within 72 in the content of the	PART I DEATH WAS CAUSED BY IMMED ATE CAUSE (a) Cardiac Tamponade	INTERVAL BETWEEN ONSET AND DEATH
This certificate should icate, writing the word be farwarded to the Ch I be used as a bunal-transorat, and in any every	Conditions, if ony, which gove rise to immediate cause (a), DUE TO DUE TO Laceration of Aorta DUE TO	
ficate fing the rded as a and i	stating the underlying couse (c)	
: This certificate, writificate, writificate	PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)	19 WAS AUTOPSY PERFORMED? YES NO
MINER: This the certificate, 4 should be far files. e 3 should be ue 3 should be ue	200 EXTERNAL CAUSE WAS 200 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port or Port of item 8)	
	20c IME OF NJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20f (Crity or town) (County) 9:30 Ppm 1 10 19 67 Of work of work Street Anne Arc	, ,
MEDICAL EXA pleose execute I director. Poge estained for you. DIRECTOR: Poggnar to buriol, crem		nd n my op n or
	ACTUAL SIGNATURE MD ASSISTANT MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
TO DEPUTY necessary, F the funeral S may be r TO FUNERAL Health prior	EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. DEPUTY MEDICAL EXAM NER Address (Street, city, town, or county)	1/11/67
TO I nec the S m TO F	230. BURIAL CREMATION, REMOVAL SIDERITY 1/16/67 ARLINGTON NATIONAL CEM. 23d .OCATION (City of Town) (Court To	NÎA
VR A15ME (5) 6M 1/67	ADDRESS AVE. 21229 250. REC'D BY REGISTRAR 256 REGISTRAR'S SIGNA DATE 11 3 1967 ACCORDED	



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00083 FOR STA HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased led, if institution Residence before admiss on) o COUNTY o STATE Page **b** COUNTY 2 40 Anne Arundel haurs after death. Maryland MARYLAND Anne Arundel Department b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outs de corparate limits, write RURAL and give nearest town) C LENGTH OF STAY N. Ib. and Millersville Glen Burnie d NAME OF HOSP TAL OR INSTITUTION (f nat in hasp to) give street address) d STREET ADDRESS S RESIDENCE ON A FARM? rundel Hospital North penal in Item 18. Give Pages ate Rt. 2, Box 300 YES -NO alang with 3 NAME OF Middle A DATE Day DECEASED OF DEATH within KERMIT **CREWS** 14 67 Ε. January # (Type or print) 19 with 1 S SEX 6 COLOR OR RACE 7 MARRIED 8 DATE OF BIRTH AGE (In years F LINDER 1 YEAR NEVER MARRIED IF UNDER 24 HRS. ost bithdoy) Months Davs Hours Male White W DOWED DIVORCED TX haurs event 1Da USUAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 11 BIRTHPLACE (State or fore an country) 12 CT ZEN OF WHAT during most of working the, even if retired Mechanic INDUSTRY COUNTRY? dny Winston-Salem, N. C. Examiner's be executed within 13 FATHERS NAME 14 MOTHER'S MAIDEN NAME Oscar Crews Mary Phipps Ξ 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address Winston-Salem ward "pending" in the Chief Medical (Yes, no er unknown) (If yes give mor or dotes of service perm Frank Voglar Funeral Home remov North Carolina CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH 70 Multiple Extreme Injuries. IMMEDIATE CAUSE (o) This certificate should s a burial-tra crematian, c writing the ward DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO storing the underlying couse should be forwarded OIS burial, a PART II OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS CERTALICATION PERFORMED? please execute the certificate. YES X pe agent, priar ta NO 2Do EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 1 of Item 18.) 3 shauld PRIMARY Extor CONTRIBUTING CAL EXAMINER: Pedestrian struck by motor vehicle CAUSE OF DEATH MEDICAL 20c TIME OF JULKY Month, Day Year 2Dd INJURY OCCURRED 3 2De PLACE OF INJURY (Home, form, 2Df (City or town) (County) (Stote) Hour ZOZOX may be retained far yaur FUNERAL DIRECTOR: Page While Not While factory, street, office bldg , etc.) 1967 Millersville 1/ 14 of work A.A. Md. at work its designated 21. I certify that I took charge of the remains described above, held on Autopsy [x] Inspection | Inquiry . ond in my opinion the funeral directar. deoth resulted from: Addident X Suicide Notural couses Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ell ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY pe 50 1/15/67 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Charles S. Petty Health (NAME (Type) Address (Street, city, town, or county) BURIAL, (REMATION DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (C'ty or Town) (County) REMOVAL (Suprity) 1/16/1967 Bunker Hill Cemetery Forsyth County, N. C. 24. FUNERAL DIRECTOR 25o. REC D BY REGISTRAR 25b REGISTRAR'S SIGNATURE VR A15ME (5) Municipy 1967 6M T/66



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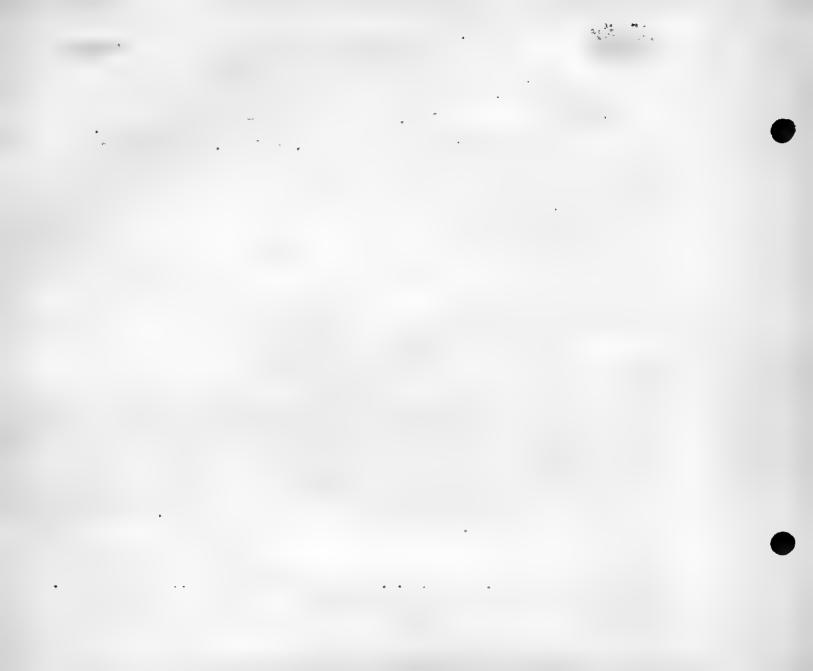
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00083 CERTIFICATE OF DEATH 00084 requires that the death certificate be executed within 24 hours ofter death signed by the attending physicion and completely filled in by the funeral burial-transit permit Then please remove carbon papers. Pages I and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. SMEryland b. COUNTY timore City a. COUNTY b. CITY OR TOWN (if outside carporate limits, MARYLAND c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest lawn) 2mos. 2 days Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in haspitol, give street address) lease remove carbon popers. d. STREET ADDRESS e IS RESIDENCE ON A FARM? 923 Dantry Ct. YES NO X Crownsville State Hosnital 3 NAME OF 4 DATE Doy Year DECEASED (Type or print) 3-#33947 Anna Marie Cumminos 19 67 DEATH 9. AGE (In years last, birthday) IF UNDER 1 YEAR S SEX I IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH Tune 28, 1925 Female White WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of wark dane during most of working life, even if retired)
Waltress 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? **INDUSTRY** Johnsentown, Pa. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, cremation, or removal, William Cummings Katherine Smith TS WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) ((If yes give war ar dates at service) 17 INFORMANT 16 SOCIAL SECURITY NO Address 198-20-4243 Hospital Records FB CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN **ONSET AND DEATH** Heart Failure IMMEDIATE CAUSE (a) TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Page 4 may be retained by the hospital or ottending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Bronchopneumonia Canditians, if any, which gave rise to immediate couse (o). DUF TO stating the underlying cause os the Apteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS) PERFORMED? CERTIFICATION NO P į 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH be detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year While at wark at wark Hour a.m. factory, street, affice bldg., etc.) 21. I certify that (I) (this haspital) attended the deceased fram 11/2/, 19 66 to 1/22, 17 67, 19 67, 19 67, 19 68 to 1/22 and that death accurred at 11/2/M, fram causes and an the date stated above. pjnous director, page 3 should should be filed with the 22b. DATE SIGNED 22a, SIGNATURE MED DIRECTOR STAFF PHYS. X 1/30/67 MD 22d. ADDRESS 22c. PHYSICIAN'S Benedict, M. D. Crownsville State Hospital.Md. NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION (County) REMOVAL (Specify) Ritchie Hgwy., A.A.Co.,
REGISTRAR | 25b. REGISTRAR'S SIGNATURE Glen Haven Memorial 2-1-1967 2Sq. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) Miarlas luck DATE FEB 2 George J. Gonce-4001 Ritchie Hgwy., Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00084 00085 death. requires that the death certificate be executed within 24 hours after death completely filled in by the funeral ave carban papers. Pages 1 and y event, within 72 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) . PLACE OF DEATH b. COUNTY a. COUNTY a. STATE Maryland Anne Arundel Anne Arundel MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If autside carparate limits. E LENGTH OF STAY IN 16 - write RJRAL and g ve nearest town) RURAL - Annapolis Annapolis 1 mo. 7 days d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS Severn. e IS RESIDENCI ON A FARM? Anne Arundel General Hospital 6 Riverdale Dr. Winchester on NAME OF Middle 4 DATE Day DECEASED DARAGO January 3 19 67 Peter DEATH Type or print) 9. AGE (In years S SEX IF UNDER 1 YEAR 1 IF UNDER 24 HRS. COLOR OR RACE 7 MARRIED DATE OF BIRTH **NEVER MARRIED** last-builday) Days Male WIDOWED DIVORCED 0 1Do. USUAL DECUPATION (G ve hind of work done IDS KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN, OF WHAT during most of working life, eve Hungary 13. FATHER'S NAME 14. MOTHER'S MA DEN NAME IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, of Armen) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17 INFORMANT Address 18. CAUSE OF DEATH (Enter only one cause per line-for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying cause has been the 19. WAS AUTOPS' PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) YES NO TV O FUNERAL DIRECTOR: After this certificate for 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2Do ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Dov. Year 2Dd. INJURY OCCURRED factory, street, office bldg., etc.) Nat While at work at work 22a. SIGNATURE 22b. DATE SIGNED STAFF ATTENDING MED. PHYS. DIRECTOR M.D. PHYS. director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S 121 Cathedral St., Annapolis, Md. Richard N. Peeler, M.D. NAME (Type) 23a BURIAL, CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF LaryCemetery Teuben11/1e 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66



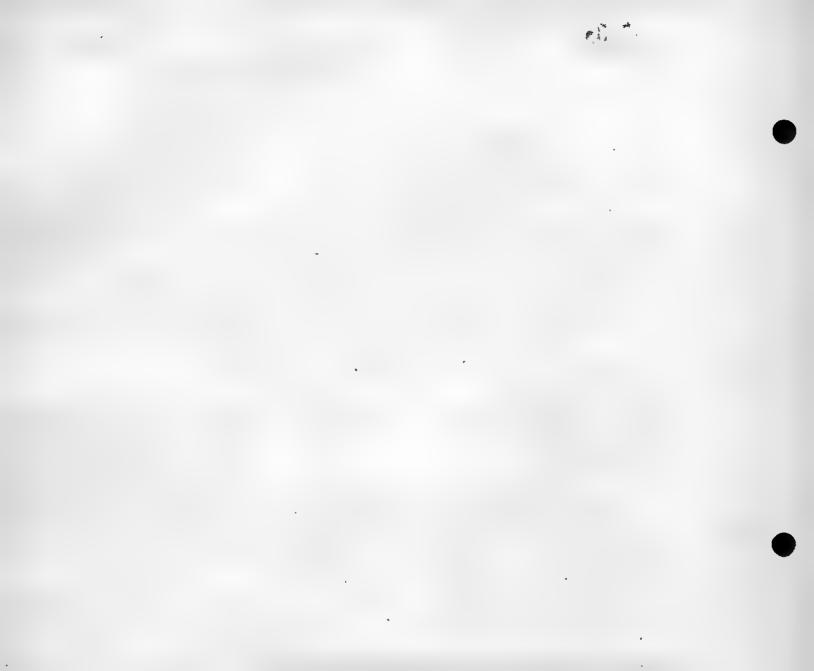
12		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
£ 780 £		DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 00086
1 24 hours after death. filled in by the funeral papers. Pages 1 and 2 nin 72 hours after death.	1.	PLACE OF OEATH a. COUNTY D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
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death certificate be ne attending physician permit. Then please tion, or removal, and i	15 (Y	S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (15 yes give war or dates of service)
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 h Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers should be filed with the State Dept, of Health prior to burial, cremation, or removal, and in any event, within 72		PART I. DEATH WAS CAUSED BY: MMEDIATE CAUSE (a) DUE TO Gave rise to immediate cause (a), stating the underlying cause last.
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NG PHY by the fter thi be deti	MEDICAL	20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, Hour a.m. 20f. (City or town) (County) (State) 4 work 19 at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)
ATTENDI retained ECTOR: A 3 should with the 8		21. I certify that (I) (this hospital) attended the deceased from 19, to 19, that (I) (we) last saw the deceased alive on 20, and that death occurred at 20, from the causes and on the date stated above. 224. SIGNATURE 225. OATE SIGNED
SPITAL OR 4 may be WERAL DIR tor, page d be filed		22c. PHYSICIAN'S NAME (Type) Robert R. HAHD 22d. ADDRESS NAME (Type) Robert R. HAHD 22d. ADDRESS ROBERT ROB
TO HO Page To FUI direc	23	REMOVAL (Specify) 1-30-67 Carlington Nat'l Carlington Val.
VR A15 (4) 20M 1/65	1 24 X	There S. Bernanco, Sevence DH, Ind DATE JAN 31 1967 Melanda Carda
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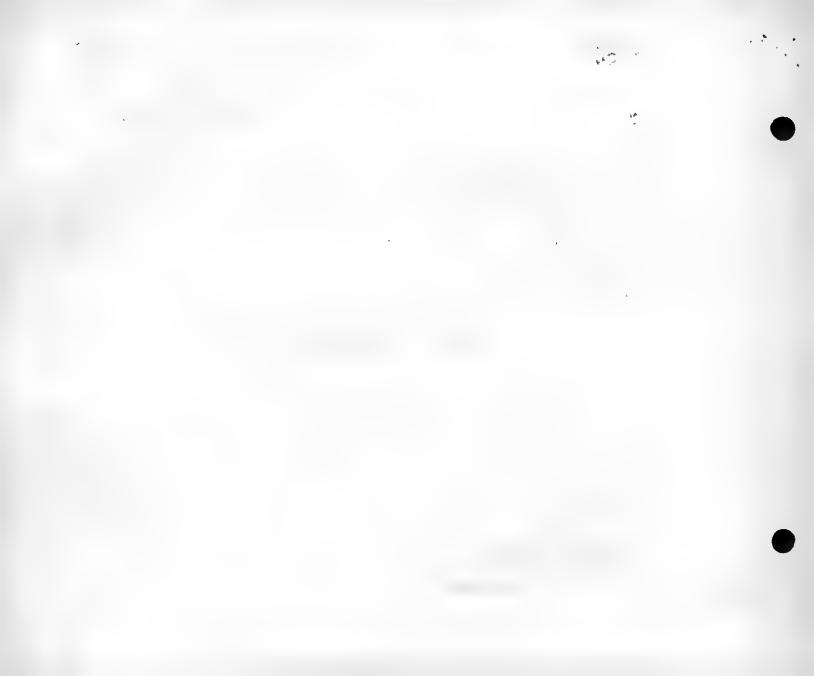
	1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
;	(M)	00086 CERTIFICATE OF DEATH 00087	
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that th	pnysician. signed by the attending physi burial-transit permit. Then p burial, crematian, ar remaval,	18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hence the couse per line for (b), and (c) DUE TO DUE TO INTERVAL BETW ONSET AND DE	ATH
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law re	been s the iar ta	kast (c)	DCV
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rsician	aspital certifica hed far it. af He	PERFORMEL YES N 20a ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.)	
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OR AI	DIRECTO	220 SIGNATURE M.D. ATTENDING MED DIRECTOR STAFF 226 DATE SIGNED 1-19-67	
SPITAL	4 may NERAL I Iar, pag Id be fil	22c PHYSICIAN'S NAME (Type) 1/14 P. STEPHENS CORNHILL St. ANN Apolis +	1D
TO HO	To FUNER director, should	230 BURIA., CREMATION. 23b. DATE THEREOF 23c. NAME OF CREMATORY 23d. JOCATION (City or Town) County (Stephen County) 24d. DOWNERAL DIRECTOR 25c. RECUE BY TOWN DOWN SIGNATURE 24d. POWERAL DIRECTOR 25d. REGISTRAR'S SIGNATURE	<u>D_</u>
	VR A15 (4) 20 M 1/66	John M. Lay to & Sais amepolis Mde DATE DATE 1967 fcharles Jud	<u>u</u>



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00088 00087 be executed within 24 hours after death bon papers. Pages I and within 72 hours after deoth and completely filled in by the funeral remove carbon papers. Pages I and USUAL RESIDENCE (Where deceased lived, if instruction Resigince before admission) PLACE OF DEATH o. COUN' COUNTY MARYLAND c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, QR/TOWN (If autside corporate limits) write RURAL and give nearest town) write RURAL and give negress town e. IS RESIDEN d NAME OF HOSPITAT OR INSTITUTION (If no) in hospital, give street address) d. STREET ADDRESS ON A FARM NO 3. NAME OF First Lost DATE DECEASED OF DEATH AGE (In years IF UNDER IF UNDER 24 HRS 6 COLOR OR RACE **NEVER MARRIED** orthdoy) Months Hours and in ony DIVORCED KIND OF BUSINESS OR 12. CITIZEN OF WHAT, (Give kind of work done 10b (County & State, or foreign country) during most of work ng life, even if retired) requires that the death certificate 13 FATHER'S NAME 14 MOTHER'S MANDEN NAME or removal, signed by the ottending phy burial-transit permit. Then 15 WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or upknown) (If yes give wor or dotes of service cremation. NTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) PART 1 DEATH WAS (AUSED BY-ONSET AND DEATH IMMEDIATE CAUSE (o) physicion. DUE TO buriol. Conditions, if any, which gave rise to immediate couse (o), DUE TO stating the underlying couse use as the loth prior to b ottending O FUNERAL DIRECTOR: After this certificate hos been lost. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) od for use of Heolth p NO [YES Page 4 may be retained by the hospital or 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING . OR CONTRIBUTING CALSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Year 20f. (County) foctory, street, office bldg., etc.) Hour o.m Not While While of work ot work . 19 , 19___, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. ... ta 19____, and that death accurred at loof M, fram causes and an the date stated above. saw the deceased alive an___ 22o, SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. MD. DIRECTOR 22d. ADDRESS director, page should be file 22c. PHYSICIAN'S NAME (Type) 2300 NAME ON CEMETERY OR CREMATORY (County) BURIAL, CREMATION 236 DATE THEREOF (Stote REMOVAL (Specify) 25by MOISTRAR SOIGNATURE **ADDRESS FONERAL DIRECTOR** VR A15 (4) 20 M 1/66 delance

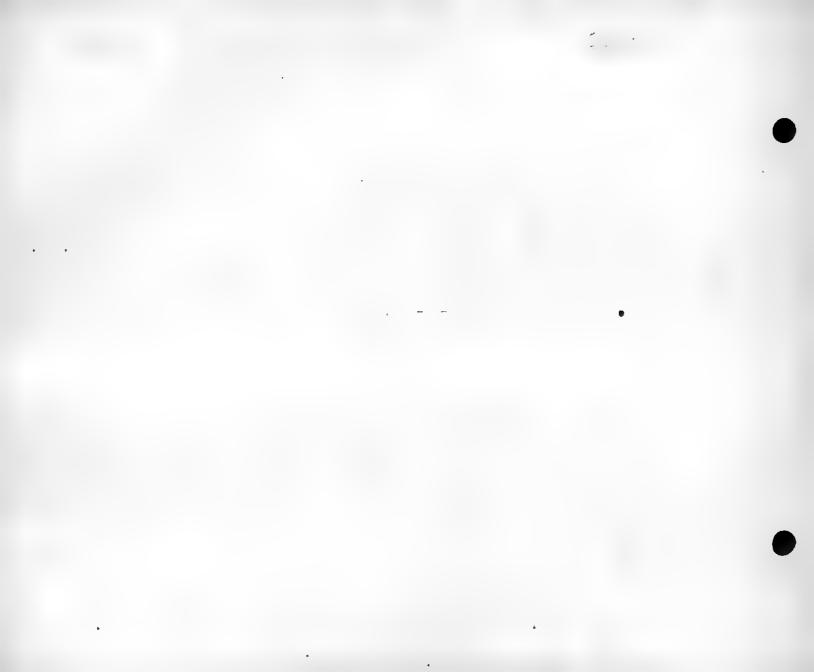


1 /2/2		DEPARTMENT OF HEALTH
	Division of STATISTICAL RESEARCH AND RECORDS	301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 S CERTIFICATE OF DEATH 00089
FOR STATE	00088 medical examiner	S CERTIFICATE OF DEATH 00089
 HEALTH DEPT. 	PLACE OF DEATH	2 USUAL RESIDENCE (Where deceased ved, if not tution Residence before admission)
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f cny delay 1, 2, and 3 m PM3. Pag Deportment rs after deat	(I pm 1210 NIL	Hulberry Roed - HANOVER
th If Cny delay is ges 1, 2, and 3 to form PM3. Page of Deportment of hours after death	d NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address)	d STREET ADDRESS e IS RES DENCE ON A FARM?
tote hou	3. NAME OF First Middle	174/2 - Mulberry RC YES NO E
hours ofter death 1f of them 18. Give Pages 1, Office along with form 1 and 2 with the State De event within 72 hours	DECEASED (Type or print) Blanke 9	DECICK OF DEATH 21 1967
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75 o 18.0 w tr	WIDOWED DIVORCED	12-18 19 1 1894 lost birthday) Months Doys Hours Min
hot. Office ond	100 JSUAL OCCUPATION (Give kind of work done during most of working life, even if ret red.) 10b KIND DF B JSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY?
8 S T S 2 S	Homemaken OWN House	Baltimore md. COUNTRY? 19.5. 19.
= 2.4	13 FATHERS NAME	TANNIE CREEN
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO 1.	7 INFORMANT Address
utec gi' i ical ical vol,	(Yes, no, or unknown) (If yes give wor or dates of service)	William DREIEK-Same out
INER: This certificate should be executed e certificate, writing the word "pending' in should be forwarded to the Chief Medical Efles. 3 should be used as a buriol-transit permit Firt, prior to burial, cremation, ar removal, and	18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)	INTERVAL BETWEEN
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L EXA	p.m. 17 of work C of work C	
MEDICAL EXAIPLES AND PROPERTY. Page 4 director. Page 4 director. Page 4 director. Page 5 directors: Page 5 designoted age 5 d	21. I certify that I taak charge of the remains described above, death resulted from: Natural causes , Accident , S	held on Autopsy, Inspection, Inquiry, ond in my opinion suicide, Hamicide, Undetermined manner
MEDICA oleose ex- director. etouned i DIRECTO	dealif lesured Horney National Causes [2], Accident [3], 3	CHIEF MEDICAL EXAMINER
ME plec plec l dir reto reto rts d	SIGNATURE Contraction	M.D. ASSISTANT MEDICAL EXAMINER
UTY Ory, Derion be Or I	EXAMINER'S 5	DEPUTY MEDICAL EXAMINER X
O DEPUTY MEDICAL EXAMINER: This necessory, please execute the certificate, the funeral director. Page 4 should be for your files. O FUNERAL DIRECTOR: Page 3 should be Health or its designoted agent, prior to	NAME (Type) 230 BURIAL CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY	Address (sheet, thy, town, or county)
5 ± 10 1	230 BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY	Parklanton Rult
P	24 FUNERAL DIRECTOR ADDRESS ADDRESS	250. RECD BY REGISTRAR 256 REGISTRARS SIGNATURE
VR A15ME (5)) 6M 1/66	Singleton Freneral Home / Llon By	cerie DATE JAN 24 1867 Scharles Judge



	Division of STATISTICAL RESEARCH AND RECORDS, 301	W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE	00089 MEDICAL EXAMINER'S C	CERTIFICATE OF DEATH 00090	
HEALTH DEPT.	PLACE OF DEATH a COUNTY A P CO MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission of STATE MASS. b. COUNTY	n) /
If any deloy is 1, 2, and 3 to rm PM3. Page Deportment of Jrs offer death.	b CITY OR TOWN (If outside corporate I mits, c. LENGTH OF STAY IN 1b with RJRAL and give nearest town) Of NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)	C CITY OR TOWN (If outside corparate I m to write RURAL and give nearest town) FRaming ham - Cowtcr d STREET ADDRESS e IS RESIDE	ENCE
ges 1, farm farm	North - ARUNDEL - Hospital	SI Shale Street YES IN	RM2
viting Pool	3. NAME OF First Middle DECEASED (Type or print) First Middle UAN PRACY	Pudley OF DEATH 19 19 G	27
	S. SEX 6 CO.OR OR RACE 7 MARRIED NEVER MARRIED 8 WIDOWED DIVORCED 8	DATE OF BIRTH 9 AGE (In years IF JNDER 1 YEAR IF UNDER 1 10 - 18 9 AGE (In years IF UNDER 1 YEAR IF UNDER 1 10 - 18 9 AGE (In years IF UNDER 1 YEAR IF UNDER 1 10 - 18 9 AGE (In years IF UNDER 1 YEAR IF UNDER 1 10 - 18 9 AGE (In years IT UNDER 1 YEAR IF UNDER 1 10 - 18 9 AGE (In years IT UNDER 1 YEAR IT UNDER 1 10 - 18 9 AGE (In years IT UNDER 1 YEAR IT UNDER 1 10 - 18 9 AGE (IN YEAR IT UNDER 1 YEAR IT UNDER 1 10 - 18 9 AGE (IN YEAR IT UNDER 1	24 HRS Min
24 hours in Item II. Office Iond 2 went	100 JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookkeeper 10b KIND OF BUSINESS OR INDUSTRY	New York City New York 12 CITIZEN OF WHAT COUNTRY? U.S.A.	
within pencil is caminer aminer les pogges nd in ar	13 FATHER'S NAME Villiam Porter Van Praag	14. MOTHER'S MAJEN NAME Grace Coolidge	
be executed within "pending" in pencil itely Medical Examinativity in itely	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN	NFORMANT Address spital Records	
be executed "pending" in medical ansit permit. Sansit permit.	18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY MMEDIATE CAUSE (o) Cercuro viaseule	are are de la ONSET AND DE	VEEN
should e ward o the Ch ouriol-tro	Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse	achirescular deserve 36002	۵,
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두 등 등 등	PRIMARY OF CONTRIBUTING C	Enter nature of injury in Part I or Part II of item 18)	
N a ta t	20c TIME OF INJURY Month, Day, Year While Not While of work of work	E OF INJURY (Home, form, 20f. (City or town) (County) (Story, street, office bldg., etc.)	itote)
	21. I certify that I taak charge of the remains described above, held death resulted fram.) Natural causes , Accident , Suicid	d on Autopsy, Inspection, Inquiry, and in my o de, Hamicide, Undetermined manner CHIEF MEDICAL EXAMINER	pinior
O DEPUTY MECCA necessory, pleose ex the funeral directar. S may be retoined in D FUNERAL DIRECTO Heolth or its design	ACTUAL SIGNATURE hucharah	M.D ASSISTANT MEDICAL EXAMINER	IGNED
O DEPUTY necessory, the funeral S may be no D FUNERAL Heolth or i	EXAMINER'S E-LINEAR OF CONTROL OF	Address (Street, city, town, or county) /-19-6/	oto)
10 I he	230 BUR AL (REMATION, REMOVAL (Specify) Burial Jan. 22.1967 Edgell Grove	Framingham Mass	ote)
VR ATSME (S)	24 FUNERAL DIRECTOR ADDRESS Vas Had For	250 REC'D BY REG STRAR 256 REGISTRAR'S SIGNATURE	E.

MARYLAND STATE DEPARTMENT OF HEALTH



1 -	1(M)	DIVISION OF 1	MARYLAND STATE DEPAR ITAL RECORDS, 301 W. PRESTON		AND 21201
(2)	: 22 ::	00090	· ·	OF DEATH	00091
	ne funeral ges 1 and 2 after death	D CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	1 MARYLAND	o. STATE Maryland	ived if institution Residence before admission) b. COUNTY Anne Arunde 1 firmits, write RURAL and give nearest town)
and	in by theses. Page 2 haurs	write RURAL and give nearest town) Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in i		Annapoli d. STREET ADDRESS	
hin 2	filled n pape ithin 7	Anne Arundel Gen	eral Hospital	1413 West	Street YES NO V
pour pour pour pour pour pour pour pour	campletely nave carbo ny event, w		MARRIED NEVER MARRIED 8.	EARLE OF DEATH J	anuary 3 1 19 67 GE (in years less thinking) Months Days Hours Man. 66 yrs
ato a	please ren	10c JSUAL OCCUPATION (Give kind of work done during most of working life eyen if retired) 13. FATHER'S NAME	10b KIND OF BUSINESS OR INDUSTRY	D. BIRTHPLACE (County & State, or foreign	on country) 12. CITIZEN OF WHAT
the of	iffending phy ermit. Then n, ar remava	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no., or upknown) (If yes give wor or dotes of serv	EARLE 16. SOCIAL SECURITY NO 17. INF.	MARY Coy, ORMANT H EARLE	HER Address #2
we required that the death certificate he executed within M hours after death	by the haspital ar attending physician. After this certificate has been signed by the attending physician and campletely filled in by the funeral be detached far use as the burial-transit permit. Their please remaye carbon papers. Pages I and 2 State Dept. of Health prior to burial, cremation, ar remayal, and in any event, within 72 haurs after death.	18. CAUSE OF DEATH (Enter only one couse pe PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) // J DUE TO Conditions, if ony, which gove rise to immediate cause (o), stoting the underlying couse (ost. (c)	r line for (o), (b), and (c).) MYO CATEDIAL IPT HY PERTENSIVE 1	FARCTION YEART DISE	
PHYCICIAN: The low	ficate has far use as Health pri	PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTED 200 ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (FEBTHER NOTICE MEDICAL CAUSE OF DEATH	BUTING TO DEATH BUT NOT RELATED TO THE 20b DESCRIBE HOW INJURY OCCURRED (En		PERFORMED? YES NO
SISAHd SI	the haspi er th's certi detached ate Dept. of	(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		OF INJURY (Home, farm, 201 (C'ty or town) (County) (State)
O HOSPITAL OR ATTENDING	Page 4 may be retained by to FUNERAL DIRECTOR: After director, page 3 should be a should be filed with the State	21. I certify that (I) (this haspital saw the deceased alive an 220. SIGNATURE	4 (eath accurred at M. ATTENDING MED DIRECTOR	1/3/ , 1967, that (I) (we) last ram causes and an the date stated abave 22b. DATE SIGNED 22b. PHYS. 2 - 6 7
CPITAL	Page 4 may be of FUNERAL DII director, page shauld be filed	22c. PHYSICIAN'S NAME (Type)		FRANKLIN ST.	HUNDONIS, MD.
TO HO	- AF	230 BURIAL, (REMALION), 23b DATE THEREOF 27b DATE THEREOF 27c DATE THEREOF	23c NAME OF CEMETERY OF CRE	N BLAO	FION (City or Town) (County) (State) ENSBURG 2Sb. REG.STIAR & SIGNATURE
	VR A15 (4) 150 25M 1/67	John M. Ja Ta + Haus	Umopolis, Ma	250 RECTO BY REGISTRAR DATE 19	37 Charles Judge

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Home/Glen Burnie. Md.

MARYLAND STATE DEPARTMENT OF HEALTH

IS RESIDENCE ON A FARM?

Year

1967

PERFORMED?

NO [

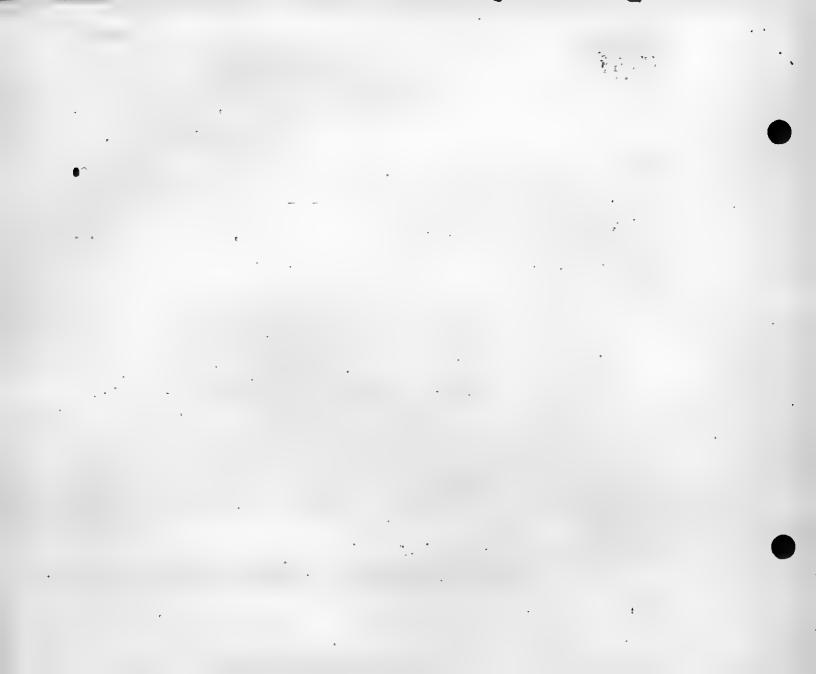
(State)

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Hours

NO X

VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00093 FOR STATE HEALTH DEPT I PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased eved if institution; Residence before admiss on) o. COUNTY 2, ohu . PM3. Page o STATE 5 COLINTY after death MARYLAND delay Deportment c. LENGTH OF STAY IN 15 CITY OR TOWN (If outside corporate imits. c CITY OR TOWN (If outside carparate limits, write RURAL and a ve nearest town) write RURAL and give pearest tawn) Russi C. AUNDMOLIS. a NAME OF HOSPITA, OR INSTITUTION (If not in hospital, a ve street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS ong with form within 72 hours Stote [YES NO hours ofter death 3 NAME OF 4 DATE Lost Month Doy Year DECEASED OF 19 6 7 MMCKCICK (Type or pnnt) DEATH S SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED ast birthdoy) Months WIDOWED DIVORCED IDo USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 12 CITIZEN OF WHAT BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Hessewife 4 should be farworded to the Chief Medical Examiner 13 FATHER'S NAME This certificate should be executed within .⊑ File 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown). (If yes give war or gates of service or removal, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) 12-22-66 cremation, DUE TO 10 Conditions if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse buriol, o 19 WAS AUTOPS PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? CERTIFICATION YES -NO 2 2Do EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ■ 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of mury in Port I or Port II of Item 18) Health or its designated agent, prior CAUSE OF DEATH 2De PLACE OF INJURY (Home, form (City or fown) 2Dd INJURY OCCURRED (County) (Stote) 2Dc TIME OF INJURY Month, Doy Year Not While foctory, street, office bldg., etc.) of work 12-22- 1966 Wer word AACE-LID of work 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection 1 Inquiry and in my opinion the funerol director. death resulted from Natural couses Suicide Homicide Accident Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) BURIAL, CREMATION, (County) (Stote) 0 REMOVAL (Specify) ChristChurch Owensuille Md 250. REC'D BY REGISTRAR FUNERAL DIRECTOR 2Sb VR A15ME (5)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o COUNTY **b** COUNTY MARYLAND c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write c. CITY OR_TOWN (If outside corporate limits_@rite RURAL and give nearest town) RURAL and give nearest townly d. NAME OF HOSPITAL (If not in hospital, give street address) STREET ADDRESS e. IS RES DENCE OR INSTITUTION ON, A FARM? There YES AT NO NAME OF 4. DATE First Middle Month Day Year DECEASED OF DEATH (Type or print) 9. AGE (In years lost-byrthday) 5. SEX 6. COLOR OR RACE IF UNDER I YEAR IF UNDER 24 HRS MARRIED NEVER MARRIED B. DATE OF BIRTH Months Days Hours DIVORCED [WIDOWED | yrs. 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 B!RTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? most of warking life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO
(Yes no or unknown) | (If yes, the wor or dollar of service) INFORMANT Address CAUSE OF DEATH [Enter only one couse per line far;(a), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** Conditions, if ony, which gove rise to immediate **DUE TO** couse (a), stoting the underlying couse lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) 19. WAS AUTOPSY PERFORMED? NO 20o. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e PLACE OF INJURY (Home, form, | 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stole) factory, street, office bldg., etc.) Hour a.m. While Nat while of work at work | p. m. that I attended the deceased from ta _...that I last saw the deceased alive or and that death occurred at M, from the causes and on the date stated above. DATE SIGNED ACTUAL SIGNATURE ALLEN PHYSICIAN'S NAME (Type) 229 JURIAD CREMATION 226. DATE THEREOF 22c NAME OF CEMPTERY OR CREMATORY 22d LOCATION (City. (State REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE 246 REGISTRAR'S SIGNATURE **ADDRESS** 240. REC'D BY REGISTRAR

Filed

TO

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VS A15 (4) 15M 10/57



1	,	DIVISION OF STATISTICAL	,	ARTMENT OF HEALTH 301 W. PRESTON STREET, B	ALTIMORE 1, MARYLAND
	_	00095	CERTIFICATE	OF DEATH	00096
l	1.	PLACE OF DEATH		2. USUAL RESIDENCE (Where dec	eased lived, If institution; Residence before admissi
ı	_	Anne Arundel b. CITY OR TOWN (if outside corporate li	maryland imits, c. LENGTH OF STAY IN 1b	Maryland	AA ete limits, write RURAL end give nearest town)
		write RURAL and give nearest town)		_	ele limits, while KOKAL and give needs town
ı		Glen Burnie d. Name of Hospital or Institution	U(if not in hospital, give street eddress)	Severn d street Address	, e. IS RESIDEN
١		North Arundel	Hospital	Evergreen Road	ON A FARI
3.		NAME OF FILE	rst Middle	Lest 4. DATE OF	Month Dey Yeer
L		(Type or print) Char	les Henry	Fox DEATH	Jan. 7, 1967
5.		SEX 6. COLOR OR RAC	7. MARRIED NEVER MARRIED B	DATE OF BIRTH 9.	AGE (In yeers IF UNDER 1 YEAR IF UNDER 24 HR lest birthday) Months Days Hours Min
10		Male White	WIDOWED DIVORCED	19 Dec. 1904	62 yrs.
ľ	de	ine during most of working life, even if rel	lired)	Y 11. BIRTHPLACE (County & State, or ke	
ŀ	13.	Tronwor key	_ Shipyard	Milton Pa- 14. MOTHER'S MAIDEN NAME	USA
		Charles E.	Tar	Clara B.	
Ĩ	5	WAS DECEASED EVER IN U.S. ARMED FO	ORCES? 16. SOCIAL SECURITY NO. 17. II	NFORMANT	Address
Į	, , ,	IB. CAUSE OF DEATH [Enter only o		Mrs. Jennie D. 1	Fox. same as 2
		IB. CAUSE OF DEATH [Enter only of PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
ŀ		IMMEDIATE CAUSE (rombosis	Sudden
l		1/xC// DUET			0
ı		gove rise to immediate cause	ы Angina Pectoris		Z yrs.
		(a), steting the underlying DUET			Erma
1	Z		(c) Arteriosclerosis DITIONS CONTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMINAL DISEASE CO	
	CERTIFICATION		Name		PERFORMED
	THE	2De ACCIDENT WAS UNDERLYING		D. (Enter nature of injury in Pert I or Pert II	
		OR CONTRIBUTING TO CAUSE OF DEATH	D1		
1	MEDICAL	20c. TIME OF INJURY Month, Day, '		CE OF INJURY (Home, farm, 20f. (City ory, street, office bldg., etc.)	or town) (County) (State)
1	ME	p.m. 19	et work et work		
		21. [certify that (I) (this hos	pital) attended the deceased from	16 August 19.65 to	7 Jan., 1967, that (I) (we)
		saw the deceased alive onO.	98na196.7, and that	death occurred all.O pM, from	the causes and on the date stated abo
		226. SIGNATURE	Manugak "		STAFF 9 Jan 1967
		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
		Hubert F	. Manuzak, M. D.		hy S. E., Glen Burnie
۱	23	REMOVAL (Specify)			TION (City, town or county) (Stele)
	-	Burial 10 Jay	n. 1967 Harmony Chur	ch Yard Mi	Ition, Pa
	24			DATE JAN 10	1967 - 20 90 000
1		TILKTEA LAMELST DO	me, Glen Burnie, Md.	CAVIE DALL TO	The state of the s

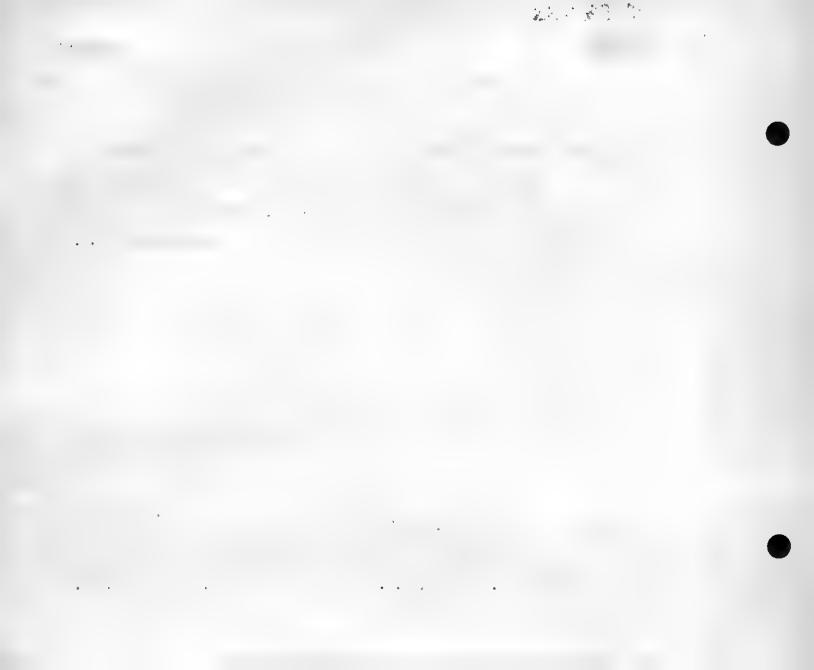


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00036 00097 y filled in by the funeral in papers. Pages 1 and 2 vithin 72 haurs after death requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY o. STATE Anne Arundel Maryland Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Hen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? 606 Jersey Ame. North Arundel Hospital YES NO X 3. NAME OF First Middle 4 DATE carban Lost Month Doy Year DECEASED 1-11 67 (Type or pnnt) W. Gaylor 19 James DEATH S SEX IF UNDER 1 YEAR 6 COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** ost birthdoy) Dovs Hours WIDOWED DIVORCED 5-31-1987 Male White 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? USA Carnenter Penna. (Weatherly (Ret Arv Dock 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending phys burial-transit permit. Then p burial, crematian, ar removal, Jennie Strutters Daniel Gaylor 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) 185-09-4307 Mrs. Pearl S. Gavlord (wife) Same as DONE INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), **DUE TO** stoting the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPS'
PERFORMED? Health NO YES TO HOSPITAL OR ATTENDING PHYSICIAN: b 20b, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Not While foctory, street, office bldg., etc.) of work ot work 21. I certify that (1) (this hospital) attended the deceased from 1-8 19 2. 7. that (1) (we) last 196 1966, and that death occurred at 440 saw the deceased alive on_ M. from causes and on the date stated above. 220. SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR M.D 22d. ADDRESS 22c PHYSICIAN'S Page 4 may NAME (Type) Glen Surnie, Maryland teicold Frnest director, shauld b 23o. BURIAL CREMATION. 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) Luzerne. Co. Penna. Freeland Cemetery 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 20 M 1/66 Glen Burnie, Md. Simpleton Richard

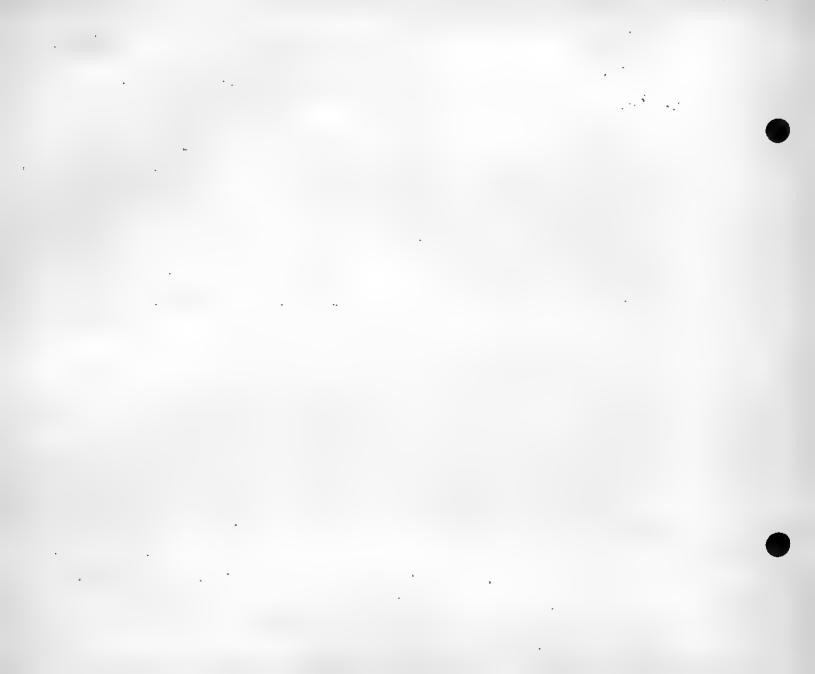
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00098 The law requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) dea a COUNTY o. STATE b. COUNTY Anne Arundel Maryland Anne Arundel tian and campletely filled in by the fur ease remave carban papers. Pages 1 and in any event, within 72 haurs after (MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 15 c CITY OR TOWN (If autside corporate amits, write RURAL and give negrest tawn) Annapolis I day Edgewater d, NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENC ON A FARM Anne Arundel General Hospital YES NOTE 3525 South River Terrace 3 NAME OF AleMiddlender DATE DECEASED Merrill GERHAR 1967 Anexander January (Type or print) DEATH 9 AGE (In years last birthday) IF UNDER 1 YEAR 1 IF UNDER 24 HRS. S SEX 6. COLOR OR RACE 8 DATE OF BIRTH 7. MARRIED T NEVER MARRIED Days Male White WIDOWED June 10, 1891 DIVORCED 10a USUAL-OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 11. BIRIHPLACE (County & Stote, or foreign country) during must of working life oven if retired) Pennsylvania 13 FATHER'S NAME IS. WAS DECEASED EVER IN U.S. ARMED FORCESS 16. SOCIAL SECURITY NO. (Yes, np, or unknown) (If yes give your products of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise ta immediate couse (a), DUE TO stating the underlying cause 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO P 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING CO Page 4 may be retained by the haspital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Day, Year 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, affice bldg, etc.) Heir am. Not While O FUNERAL DIRECTOR: After 21 | certify that (1) (this descript) attended the deceased from DEC-26, 1966, to Jan. 12, 1967, that (1) (ast) last saw the deceased glive on Jan. 12, 1967, and that death accurred at ______M, from causes and on the date stoted above. director, page 3 shauld shauld be filed with the saw the deceased alive on... 22g. SIGNATURE 22b. DATE SIGNED DIRECTOR PHYS ADDRESS 22c PHYSICIAN S NAME (Type) 59 Franklin St., Annapolis, Md. Richard I. Hochman, M.D. 23a BURIAL (REMAT ON REMOVALISPECTY) OF CEMETERY OR CREMATORS 238, BOYATION (City or Town) (County) (State) 25h REGISTRAR & SIGNATURE VR A15 (4) 25M 1/67



4	1	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M	ARYLAND
/	= = = (\\\		00098 CERTIFICATE OF DEATH 00	0099
	24 hours after death. filled in by the funeral apers. Pages 1 and 2 n 72 hours after death.	1.	A COUNTY	sidence before admission)
	~ ~ ~ ~		ANNE ARUNDEL MARYLAND ANNE A	RUNDEL
	s af by t Page Irs a		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b	and give nearest town)
	hour Is. In hour	-	ANNAPOLTS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE
	fille paper hin 72	,	NAME OF THE PARTY	e. IS RESIDENCE ON A FARM? YES NO X
	uted within 24 hours afte completely filled in by the yet carbon papers. Pages event, within 72 hours aft	3.	NAME OF FIRST Middle Jast I A BATE Month	Day Year
	executed within and completely remove carbon In any event, with		(Type or print) LAURA ARLENE GERRIOR DEATH JANUARY	6 19 67
	and con remove	5.		YEAR IF UNDER 24 HRS. Days Hours Min.
	exection and remains and remai	10	T VV WIDOWED DIVORCED A 21-1073 // yrs.	
	be ician ase nd ii	du	rring most of working life, even if retired) // INDUSTRY / / / / / / / / / / / / / / / / / / /	TIZEN OF WHAT
	certificate nding physi Then ple	13	FATHER'S NAME HOUSEWITE LYNN MASS.	U. J. H.
	rtific ing I Then mov		JUDSON CONDON ALICE HAYNES	
	tend it	1 (Y	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address es, no., or winkown) (If yes give war or dates of service))
	the death certificate be except the attending physician are sit permit. Then please reinmandon, or removal, and in a	1	LINCENT I. LENKION	<u></u>
	the sy th		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
	cian cian ed t trar , cr.		190 IMMEDIATE CAUSE (a) Conomo to sis	
	es t sign sign urial urial	1	Conditions, If any, which (b)	
	ing print be properties to be		gave rise to Immediate cause (a), stating the DUE TO	
	w rendicendias bas bas the		underlying cause last. (c)	
	The law requires that the death or attending physician. sate has been signed by the atter ruse as the burial-transit permit ealth prior to burial, cremanon, or	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
	Kallo tallo for hea	15	20a. ACCIDENT WAS UNDERLYING 3 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.)	YES NO
	O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. I FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be detached for use as the burial-transit should be filed with the State Dept. of Health prior to burial, cremater than the state Dept.	CERI	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	HYS he h this etac etac Dep	CA2	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bidg., etc.)	nty) (State)
	NG P by t fter be d state	MEDICAL	Hour a.m. While Not While at work at work at work	
	NDI ned R: A culd the S		21. I certify that (A (this hospital) attended the deceased from 23 October , 19 66 to 6 January, 19 6	
	ctai ctai sho ith i		saw the deceased alive on 5 January 19 67, and that death occurred a 2:50 M, from the causes and on the	e date stated above.
	OR be JIRE 38e 3		The sent M.D. ATTENDING MED. STAFF DIRECTOR DIRE	7/60
	TAL may		22c. PHYSICIAN'S 22d. ADDRESS	1
	Page 4 ms O FUNERAL director, p		BODK WARD G. G. 1 BON, 100 BON NAVAL HOLD TIAL, ANNUA CLIES, 1	AD.
	Page of Floor	23	REMOVAL (Specify) / // /// /// /// /// /// /// /// ///	nty) (State)
	·	2	FUNERAL DIRECTOR ADDRESS 256. REGISTRAR 256. REGISTRAR 256. REGISTRAR'S	
	VR AIS (4)	A	toku M. Toy Toy Acus (Ciuc polis Md. DATE JAN 10 1967	A JAMES AND THE
	20M 1/65			4-9



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00099 00100 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY n STATE b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND ician and campletely filled in by the fu lease remove carban papers. Pages 1 and in any event, within 72 hours after b CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Annapolis Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Anne Arundel General Hospital 316 West Street NO TY 3 NAME OF Lost 4 DATE Month Year DECEASED Hervey Oliva (Type or print) DEATH Jamuary 19 67 GILMORE 9. AGE (in years lost birthday) S. SEX 6. COLOR OR RACE 8 DATE OF BIRTH IF UNDER I YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED Dovs Hours December 12,1909 WIDOWED DIVORCED Male White 10a USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of warking life even if retired **COUNTRY?** U.S. Canada 14-MOTHER'S MAIDEN NAME 13 FATHER'S NAM ar remay orgienne 16. SOCIAL SECURITY NO. WAS DECEASED EVER IN J.S. ARMED FORCES (Yes, no. or inknown) (If yes give wor or dates of service 18. CAUSE OF DEATH (Enter only one couse per fine for (o), (b), and (c),) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEAT PART I. DEATH WAS CAUSED BY: DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse je H 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) letached far use NO 20b, DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Part II of item 18. 20n ACC DENT WAS LINDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year Hour o.m. 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) O FUNERAL DIRECTOR: After this foctory, street, office bldg., etc.) Not While 21 | certify that (1) (this hospital) attended the deceased from 196- 7 that (1) (we) last director, page 3 shauld should be filed with the from causes and an the date stated obove saw the deceased alive an SL and that death occurred a STONATURE 22b. DATE SIGNED M.D. DIRECTOR 22d, ADDRESS NAME (Type) S. Beck. M.D. Edward 73 Franklin St., Annapolis, Md. 23b DATE THEREOF (County) 2So REC'D BY REGISTRAR REGISTRAR'S SIGNATUR VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY b. COUNTY AND CO o. STATE b. CTY OR TOWN (If autside carparate mits, write RURAL and give safest tawn) c LENGTH OF STAY IN 15 c. C.TY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Allew GORNIC d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Give Pages 1, DOA-NORTH. ARONDEL -YES NO 3 NAME OF Month Doy Year DECEASED (Type or print) DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S SEX last birthday) 12-29-07 WIDOWED ony event 24 hours 10a USJAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 C TIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY ABORE R 03/7 14 MOTHER'S MAIDEN NAME LOLDY'S JAN KOWSKI 16 SOCIAL SECURITY NO 17. INFORMANT or removal, pending" IDA WEERYNIAK 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) NTERVAL BETWEEN PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (O) Certerorelleranis buriol, cremotion, Canditions, if any, which gave rise ta immediate couse (a), DUE TO stating the underlying cause 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLITING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO F 200 EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 1 of item 18.) AL EXAMINER: **CAUSE OF DEATH** 20c TIME OF INJRY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (State) factory, street, affice bldg , etc.) Not While at wark 21. I certify that t-took charge of the rema or described above, held an Autopsy Inspection 7 Inquiry [and in my opinion Accident . Suicide . Hamicide | death resulted Matural causes 🖃 Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 5 may be r ro FUNERAL Heolth or ri DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) 23a BURIAL, CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b DATE THEREOF Burca 2So. REC'D BY REGISTRAR REGISTRAR S SIGNATURE 24. **TUNERAL DIRECTOR** VR A15ME (5) DATE JAN Melianto 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00105 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death dead 2. USUAL RESIDENCE (Where deceosed lived, if institut on Residence before admission) PLACE OF DEATH o. COUNTY o. STATE **b** COUNTY and completely filled in by the fun fremove carbon papers. Pages 1 in any event, within 72 hours after Anne Arunde 1 MARYLAND Maryland Anne Arundel b CITY OR TOWN (If autside corparate limits, write RURAL and give neorest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If guitside corporate limits, write RURAL and give negrest fown) Annapolis Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Anne Arundel General Hospital 19 Hill Street YES 🗔 NOVE NAME OF Middle 4 DATE Doy Year DECEASED (Type or pnnt) Ellen **Emily** GRANT DEATH anuary 18 19 67 S SEX 6. COLOR OR RACE IF UNDER 24 HRS 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR lost birthday) Months Doys Haurs Female White March 21, 1891 WIDOWED X DIVORCED 100. USUAL OCCUPATION (Give kind of work done TOD KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if refired)
Clerk INDUSTRY COUNTRY 2 Annapolis Maryland
14. MOTHER'S MAIDEN NAME Printing U. S. 13. FATHER'S NAME the attending phys cremotion, or removo William H. Matilda Thomas 1s. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service 216-64-5552A Son- Clarence H. Grant same as #2 .above IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN signed by the buriol-tronsit p PART I. DEATH WAS CAUSED BY. ONSET AND DEATH by the hospital or attending physician. DUE TO Conditions, if ony, which gove 8050/EROSIS rise to immediate couse (a). DUE TO stating the underlying cause d far use as the of Heolth prior to PHYSICIAN: The low lost hos PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1/61 19. WAS AUTOPSY PERFORMED? TERTIFICATION NO certificote 20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, O FUNERAL DIRECTOR: After this (City or fown) (County) (State) Hour o.m. factory, street, office bldg., etc 1 Not While TO HOSPITAL OR ATTENDING ot work at work 2]. I certify that (1) (this haspital) attended the deceased from 1845. 19. that (I) (we) last be retoined director, page 3 should should be filed with the saw the deceased alive an / and that death accurred at fram causes and an the date stated above. 220. AGNATURE 22b. DATE SIGNED ATTENDING M D DIRECTOR PHYS PHYS PHYSICIANS 22d ADDRESS Poge 4 moy NAME (Type) Edward S. Beck Franklin St. 230. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAE (Specify) 1/23/67 Naval Academy Cemetery Anna polis A.A. Md24. FUNERAL DIRECTOR 250 REC'D BY REGISTRAR 25b. REGISTRAR S SIGNATURE Beverley E. Hopping leavelen 1967 25M 1/67 Hopping Funeral



(A)	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 00103
by the turstal and 2 should death.	L. PLACE OF DEATH a. COUNTY ANVE ARUNDEL MARYLAND b. CITY OR TOWN (II outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (II outside corporate limits, write RURAL and give nearest town)
hours after	FORT GEORGE G. MEADE 59 DAYS d. Name of Hospital or Institution (ii not in hospital, give street address) KIMBROUGH ARMY HOSPITAL 6. IS RESIDENCE ON A FARMY FESTOR OF THE PROPERTY OF THE
-	3. NAME OF First Middle Last 4. DATE Month Dey Veer (Type or print) HELEN P. GRAY DEATH JANUARY 20 19 67
l	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 14 HRS. Part
	10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife None Prince George, Virginia USA 14. MOTHER'S NAME Lester Tucker
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (Hyesigive were refers observice) 299-// Theodore Gray (husband) 5703 Gist Ave 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (e).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) GENERALIZED METASTATIC CARCINOMA OUE TO Conditions, if eny, which gave rise to immediate cause
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO OR CONTRIBUTING OF CAUSE OF DEATH OR CONTRIBUTING OF CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
Ш	20c. TIME OF INJURY Month, Dey, Yaer Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Homa, ferm, Hour a.m. While Not While Pom Hour alm. 19 et work all
	21. I certify that 21) (this hospital) attended the deceased from 23. Nov. 19.60, to 20. Jan 1967, that (2) (we) last saw the deceased alive on 20. Jan 19.67, and that death occurred at 2.30, from the causes and on the date stated above. 22e. SIGNATURE M.D. ATTENDING MED. STAFF PHYS. 20 Jan 67 SIGNED 22c. PHYSICIAN'S NAME (Type) JORGE J. RAMIREZ, CPT, MC 22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD
1	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
-	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS / 258. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

The second

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00104 00103 death. requires that the death certificate be executed within 24 haurs after death the funeral ages 1 and 2 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY . r filled in by the tune in papers. Pages 1 a vithin 72 hours after d Anne Arundal Marvland MARYLAND c LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). write RJRAL and give nearest jawn)
Crowns VIIIe Annapolis days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? Rt 3 Crownsville State Hospital Box 28-A NO S YES 🖂 carban 3 NAME OF Middle First Lost DATE Month Dov Year completely DECEASED Type or print) #34244 OF 10 1967 Elmer Green DEATH S SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years tast birthdoy) Months Hours 9/2/02 ΔUD Sep DIVORCED Nearo WIDOWED Male TDo USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OF 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? 115A during most of working life, even if retired)
Truck Driver INDUSTRY Maryland 13 FATHER S NAME 14. MOTHER'S MAIDEN NAME burial-transit permit. Then b burial, crematian, or remaval, Edward Green attending | INFORMAN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) Records Unknown No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) the ONSET AND DEATH PART I. DEATH WAS CAUSED BY Carcinoma of Liver IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gove rise to immediate cause (a). DUE TO stoting the underlying couse as the priar tal has been lost. WAS AUTOPS)
PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) CERTIFICATION be detached far use State Dept, af Health Psychotic Depressive Reaction YES 🗔 NO O FUNERAL DIRECTOR: After this certificate PHYSICIAN: 20o ACCIDENT WAS UNDERLYING [7] 20b, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year Not While foctory, street, office bldg., etc.) of work of work 1/10/ , 19<u>67,</u> that (I) (we) last 1967 . ta 21. I certify that (I) (this haspital) attended the deceased fram 176/ Page 4 may be retained director, page 3 should should be filed with the 1/1061967, and that death accurred a4:25 M, from causes and an the date stated above. saw the deceased alive on. 22b. DATE SIGNED 22n. SIGNATURE STAFF X 1/10/67 M.D. DIRECTOR PHYS. PHYS 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) Crownsville State Hospital, Md Benedict. 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, DATE THEREOF LOCATION (City or Town) REMOVAL (Specify) 2Sb. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 108 W WAS

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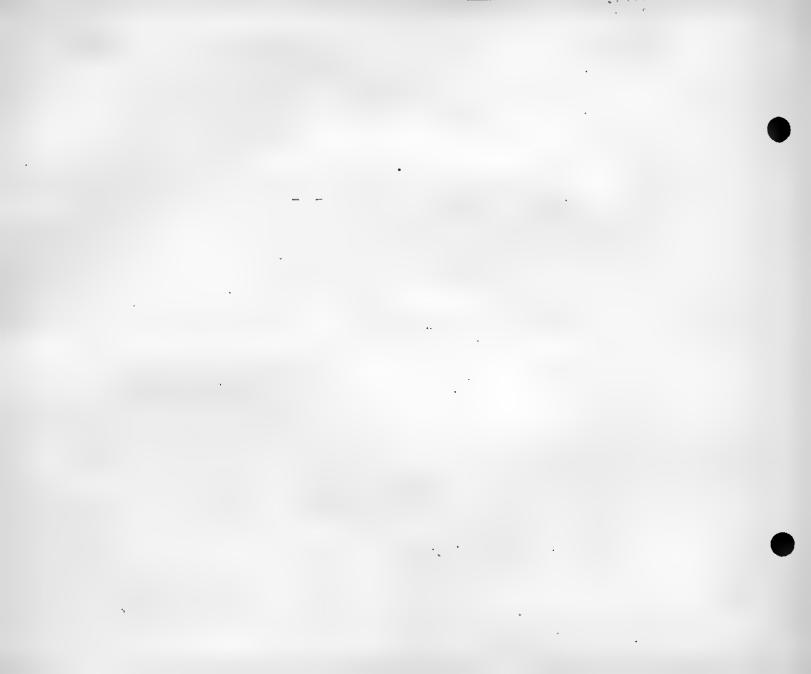
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00104 CERTIFICATE OF DEATH 00105 The low requires that the death certificate be executed within 24 haurs after death and completely filled in by the funeral remove carbon papers. Pages 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND and in any event, within 72 hours after TOWN (If outside carparate fimilis, c. LENGTH OF STAY IN 1b (If outside carparate limits, write RURAL and give nearest town) z. CITY OR TOWN rte RURAL and give nearest tawn) INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO attending physician was carbon nermit. Then please remove carbon virt Middle NAME OF DATE Last Day Year DECEASED OF DEATH GREENE RSO K (Type or print) IF UNDER 1 YEAR 8 DATE OF RIRTH (In years S SEX 6 COLOR/OR RACE MARRIED **NEVER MARRIED** purhicay) Months Davs Hours WIDOWED 1Ga USUAL OCCUPATION (Give kind at work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during mas at warking life eyen if retired) COUNTRY? 13 FATHER'S NAME director, page 3 should be detoched for use os the burial-transit permit. Then pleshould be filed with the State Dept. of Health prior to burial, crematian, or removal, 16 SOCIAL SECURITY NO. ARMED FORCES? (Ves, na, or unknown) (If yes give war ar dates at service INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) ONSET AND DEATH PART I, DEATH WAS CAUSED BY: Hypertensive Cardiovascular Disease IMMEDIATE CAUSE (a) signed by Page 4 may be retained by the hospital or ottending physician. DUE TO Canditians, if any, which gave nse ta immediate cause (a), DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) MEDICAL CERTIFICATION NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (State) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (County) 20c. TIME OF INJURY Month, Day, Year Hour a.m. Nat While factory, street, affice bldg., etc.) at work 19 59 to 21. I certify that (i) (this haspital) attended the deceased fram_ , 1967, that (I) (we) last Jan-19 67, and that death accurred at an M, from couses and an the date stated above. saw the deceased alive an .Tan 22b. DATE SIGNED 22a. SIGNATURE ATTENDING XX PHYS. M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN S Codd M.D. Francis I. Severna Park, Maryland NAME (Type) NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION 23b. DATE THEREOF PUNERAL DIRECTOR Charles



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21203 00106 00105 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death death. the attending physician and campletely filted in by the funeral sit permit. Then please remove carban papers. Pages Land nation, or removal, and in any event, within 72 hours offer death 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY ANNE ARUNDEL MARYLAND ANNE ARUNDEL b CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) write RURAL and give nearest town) 10 DAYS RURAL - GLEN BURNIE RURAL- GLEN BURNIE IS RES DENCE ON A FARM? d NAME OF HOSP TAL OR INSTITUT ON (If pat in haspital, give street address) d. STREET ADDRESS EIM AVE GARLAND PARK YES NO IX NORTH ARUNDEL HOSPITAL 4 DATE 3. NAME OF Middle First Lost Manth Doy Уеог DECEASED JANUARY 1967 Type or print GREENWALD DEATH **JOHN** F UNDER IF UNDER 24 HRS YEAR S. SEX 8. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7 MARRIED NEVER MARRIED last birthday) Manths Days Hours WIDOWED DIVORCED TITLY 8 1891 WHITE 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11, BIRTHP_ACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) COUNTRY TISA AUSTRIA A PT STEPT 14. MOTHER'S MAIDEN NAME Anthony Greenwald Rosina Regget 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, na, ar unknawn) (If yes give war ar dates of service 056/10/4298 Mrs. Heles A. Greenwald Same as #2 INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b) and burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the last. WAS AUTOPS! PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO <u>5</u> 205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF AUURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) (State) factory, street, affice bldg. etc.) Nat While at wark at work 21. I terrify that (H) (this haspital) attended the deceased fram. ___, that (I) (we) last and that death accurred at 11.40 M, fram causes and an the date stated above. be filed with the saw the deceased alive on. 220. SIGNATURE 22b ATTENDING PHYS M.D. DIRECTOR PHYSICIAN'S 22d. ADDRESS 1672 Worth Brun Kat RD Baltizz ANNAPOLIS shauldt 23d LOCATION (City or Town) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) (State) 23o. BURIAL, CREMATION, REMOVAL (Specify) Jan. 23, 1967 Glan Haven Cemeterv Glan Burnie, Md. 250. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 967 Charlen R.V. SINGLETON GLEN BURNIE DATE 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. 24 hours after death, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a Armey Arundel Marstand b. COUNTY MARYLAND Anne Arundel Pages CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie Life RFD # 7 Pasadena .≘ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Treetop Farm Arundel Hospital Morth YES P NO executed within in any event, with 3. NAME OF First Middle DATE Month 4. Day DECEASED Mary C. 19 67 Groom (Type or print) Comple DEATH AGE (In years | IF UNDER LYEAR | IF UNDER 24 HRS. | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED female white 6-28-79 WIDOWED & DIVORCED [tending physician 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fereign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY and Marylan d Housewife Home d∎ath certificate 13. FATHER'S NAME removal, 14. MOTHER'S MAIDEN NAME Christine Sellers George Wilbert Wilson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT ed by the attent transit permit. , cremation, or r Address (Yes, no. er unkown) | (If yes nive war or dates of service) Family Records 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN law requires that tille I-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a) signed been signer the burial-t or to burial, DUE TO Conditions, if any, which gave rise to Immediate DUE TO cause (a), stating the underlying cause last. has 98 CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA ED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMED? certificate the hospital or YES X NO I PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part I or Part II of Item 18.) detached for the detact of least of lea OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. After Id be d While Not While p.m. at work at work OR ATTENDIN 21. I certify that (i) (this hospital) attended the deceased from 12-191966 3 should with the and that death occurred ak://AM, from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE DATE SIGNED EN IN page MED. STAFF ATTENDING DIRECTOR PHYS. O HOSPITAL O FUNERAL director, pa should be fil ADDRESS 22c. PHYSICIAN'S NAME (Type) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION. REMOVAL (Specify) Parkwood Cemetery Parkville, Maryland Buria. 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS Sons. Towson, Maryland VR A15 (4) 20M 1/65



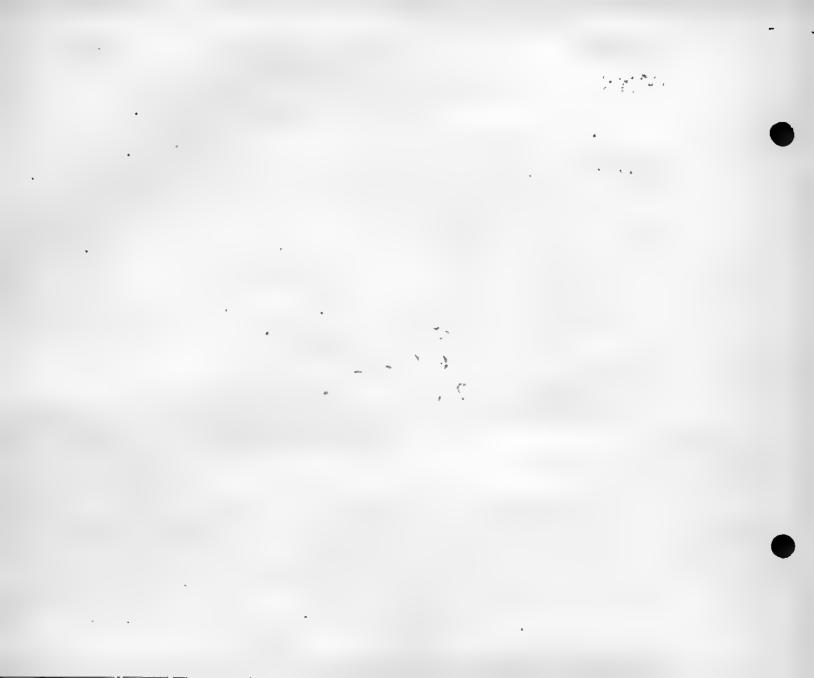
1 1/1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				
- 27 -	00107		OF DEATH	00108	
hours after death by the funeral s. Pages 1 and 2 hours after death	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest power)	MARYLAND	o. STATE	lived, if institution Residence before odm ssion) b. COUNTY limits, write RURAL and give nearest tawn)	
ithin 24 hours y filled in by on popers. P within 72 hour	d NAME OF HOSPITAL OR INSTITUTION OF IN hospital 3 NAME OF DECEASED	11-2A	STREET ADDRESS Lost 4. DATE	e IS RESIDENCE ON A FARM? YES NO M	
ate be executed within 24 rician and completely filled in lease remove carbon paper and in any event, within 72	(Type or pinnt) (VCDS) C. SEX, 6 CAPOR OR RACE 7. MARRIE WIDOW	D DIVORCED	ATE OF BIRTH 9 A	GE (In years IF UNDER 1 YEAR IF UNDER 24 MRS set burthday) Months Doys Hours Min.	
certificate be	during most of working title, even if retired)	INDUSTRY	MOTHER'S MAIDEN NAME	n country) 12 CITIZEN DE WHAT COUNTRY	
equires that the death certificate by physician signed by the ottending envision burial-transit permit. Then please burial, cremation, or removal, and it	(Yes, ng, or unknown) ((If yes, nive wor or states of service) // CAUSE OF DEATH (Enter only one couse per line PART DEATH WAS CAUSED BY:	217-07-3387 WC for (o), (b) and (c)).	Kleinnfack Leinnfack	Address Alico Tille INTERVAL BETWEEN ONST AND DEATH	
PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death e hospitol or ottending physician. his certificate has been signed by the ottending ethicican and completely filled in by the funeral stocked for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death	Conditions, if ony, which gove rise to immediate cause (o), stating the underlying cause last.	bertewine Card	iorasoular de	very years	
ICIAN: The law repitol or ottending rificate has been of for use as the of Health prior to	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTION	G TO DEATH BUT NOT RELATED TO THE T	TERMINAL DISEASE CONDITION GIVEN I	N PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO	
rsician ospitol certifica hed for hed for	20b 20c ACCIDENT WAS UNDERLYING 20b	DESCRIBE HOW INJURY OCCURRED (Ente			
NING PHYSIC by the hospit fler this certi be detoched State Dept of	Hour o.m. 19 Wh	nile Not While tectory, s	street, office bldg., etc.)	(County) (State)	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Poge 4 may be retained by the hospital or ottending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detoched for use as the burial-transhauld be filled with the State Dept of Health prior to burial, creating.	saw the deceased alive an Reserved Alive and Reserv	$\frac{7}{6}$ 19 $\frac{66}{6}$, and that de	2 5 7 may 10 m	ram causes and on the date stated abave	
TO HOSPITAL TO HOSPITAL Poge 4 moy To FUNERAL Go 5 91 Shauld be file	230. BURIAL CREMATION, 236. DATE THEREOF PEMOVAL (Specify) 236. DATE THEREOF 24. FUNERAL DIRECTOR	ADDRESS	A 250 RECD BY REGISTRAR DATE 1 0 19	25b REGISTRARS SIGNATURE OCUMBES SUBJECT OCUMBES OCUMBES	

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00109 requires that the death certificate be executed within 24 hours after death phys cian and completely filled in by the funeral eff. Diegse remove carbon papers. Pages 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel a. COUNTY Anne Arundel Maryland carbon papers. Poges 1 ent, within 72 hours after MARYLAND b CITY OR TOWN (If outside carparate limits, C LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) write RURAL and give nearest town) Days XDMX XXXXXXX X XXX Glen Burnie Glen Burnie d. STREET ADDRESS 500 Broadview Blvd. Ferndale, Glen Burnie Md. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

North Arundel Hospital e IS RESIDENCE ON A FARM? n ony event, within 72 YES NO V Yeor 6 Middle 3 NAME OF First 4 DATE Jan DECEASED John Hammons (nmi) 19 (Type or print) DEATH IF UNDER 24 HRS. S SEX 6 COLOR OR RACE AGE (In years IF UNDER 1 YEAR 7. MARRIED **NEVER MARRIED** 8. DATE OF BIRTH last birthday) Manths Hours Male White DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10g USUAL OCCUPAT ON (Give kind of work done quimbluoft de Last kand fier hab it ter ibq) INDIUSTRY . **COUNTRY?** United Atates West Virginia Laborer 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME Emily Fowler Pete Hammonis the attending phasit permit. Then mation, or remev 17. INFORMANT Address IS WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, or unknown) (If yes give war ar dates of service) 32-221938-A Mrs. Jean Miller (Daughter) Same as #2 signed by the after buriol-tronsit permi burial, cremation, o INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I, DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital or attending physician. DUE TO 4 week Conditions, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Heolth pri≡r to etoched for use os the Dept. of Heolth pri≡r to last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MEDICAL CERTIFICATION YES 🔲 NO PHYSICIAN: 20o, ACCIDENT WAS UNDERLYING [2] 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Not While factory, street, affice bldg., etc.) at work at work pital) attended the deceased fram Nov & , 1960, ta Jan 1, 1967, that (1) (we) last you. / 1967, and that death accurred at 75 M, fram causes and an the date stated abave. 21. I certify that (I) (this haspital) attended the deceased fram Nov & saw the deceased alive an_ 22b. DATE SIGNED 22g. SIGNATURE MED DIRECTOR M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) KOBERT NABOLINS AT 1 400 602:4 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23b. DATE THEREOF (County) Park Glen Burnie, Md. REMOVAL (Specify) Jan.5.1967 Glen Maydas Rurial 250" REC'D' BY REGISTRAR ? 2Sb - REGISTRAR'S-SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Glen Burnie, Md. R.V. Singleton



- 1 (M)	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMON.					
FOR STATE	00109 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	0110				
HEALTH DEPT.	1. PLACE OF DEATH 9. COUNTY ADDR ARUNDEL MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Res a. STATE 1 and b. COUNTY ATTICLE AT					
lelay is cessary, d 3 to the funeral Page 5 may be State Department hours after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5 wks. Glen Burnie	nd give nearest town)				
	d. NAME OF HOSPITAL OR (NSTITUTION (if not in hospital, give street address) North Arundel Hospital 1250 Aster Dr.	ON A FARM? YES NO X				
any dela 2, and PN3. P the St 72 hou	3. NAME OF First Middle Last 4. DATE Month DECEASED (Type or print) ELLA J. HARRIS DEATH Jan.	0ay Year 8 19 57				
urs after death. If an 18. Give Pages 1. 2 along with form Pages 1 and 2 with in any event within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years if Under 1 last birthdey) Months 0 79 yrs. Months 0 1 1 1 1 1 1 1 1 1					
	during most of working life, even if retired) INDUSTRY Lake City - Tenn. U.	IZEN OF WHAT INTRY? . S . A .				
	13. FATHER'S NAME (UNKNOWN) (UNKNOWN)					
in 24 ho ii in Iten r's Office iif. File	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes gire war or dates of service) 212-4D-8166 T(William J. Bratcher - Same as # 2					
EXAMINER: This certificate should be executed within 24 hours after death. If any delay is the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1. 2, and 3 to should be forwarded to the Chief Medical Examinar's Office along with form PM3. Page files. Files. Files. Files abould be used as a burial-transit permit. File pages 1 and 2 with the State I designated agent, prior to burial, cremation, or removal, and in any event within 72 hours a	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, If any, which gave rise to immediate couse (a), stating the underlying couse last. (c)	INTERVAL BETWEEN ORSET AND DEATH				
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?				
		tv) (State)				
INER: TI ificate, be forw ge 3 sh ed agen	Hour e.m. While Not While Pactory, street, office bidg., etc.)	/				
the certification of the certi	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, death resulted from, Natural causes, Accident, Suicide, Homicide, Undetermined manner [and in my opinion				
2 " 4 E E S	ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER X	22. DATE SIGNED				
O DEPUTY MEDI please execute director. Page retained for yo o funeral director of Health or it	EXAMINER'S NAME (Type) ELMER G. LINHARDT, ADDADIS, Md. address (Street, city, town, or county) 23a. BURIAL (CREATION,) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)	,				
52455	Burada (Specify) 1/11/67 Glen Haven Memorial Pk. Glen Burnie, Ma 24. FUNERAL DIRECTOR ADDRESS 125a. RECYP. BY REGISTRARY 2007					
VR AISME (5)	Singleton Funeral Home/Glen Burnie, Maryland DATE JAN 11 967	- Constant				

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death ceptificate be executed within 24 hours after death the funeral ages 1 and 2 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased aved, if institution Residence before admission) o. COUNTY o. STATE **b.** COUNTY Anne Arundel Anne Arundel Maryland MARYLAND kian and campletely filled in by the flease remove carban papers. Pages ond in any event, within 72 hours affg b CITY OR TOWN (If autside corporate I mits, write RURAL and give nearest town) c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b 12 hrs Annapolis nnapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Anne Arundel General Hospital 9 Poplar Ave.. NO X NAME OF Middle First Month Lost DATE Year DECEASED Douglas HAWKINS, Jr. 19 67 January (Type or print) Lawrence DEATH AGE (In years lost birthday) IF UNDER I YEAR S SEX IF UNDER 24 HRS. 6. COLOR OR RACE NEVER MARRIED 8. DATE OF BIRTH 7. MARRIED Months Hours 12 Male Negro WIDOWED DIVORCED Jan. 14. 1967 IDo USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR 13. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? Anne Arundel, Maryland U.S. Hawkins 14 MOTHER'S MAIDEN NAME burial, crematian, ar remaval, Mary Catherine Ross Donglas Lawrence William Sr. 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dotes of service) None Hospital records. INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per line for to), (b), and (c)) signed by the burial-transit p PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) by the hospital or attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse certificate has been 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) K'X ON 25 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) 20o ACC DENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e PLACE OF INJURY (Home, form, (City or town) (Stote) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (County) Not While factory, street, office bldg., etc.) of work 19 67 to Jan. 14 , 19 67, that (1) (900) last 21 I certify that (1) (the compatible attended the deceased from Jan. 14 Page 4 may be retained director, page 3 should should be filed with the Sand 14 1967 , and that death occurred at M, from couses and an the date stated above spw the deceased alive an_ 22b DATE SIGNED XIX DIRECTOR MD. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Antonio M. Rivera, M.B. SouthRivMedCent., Edgewater 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCAT ON (City or Town) (Stote) 230 BUR'AL, CREMATION Buriel

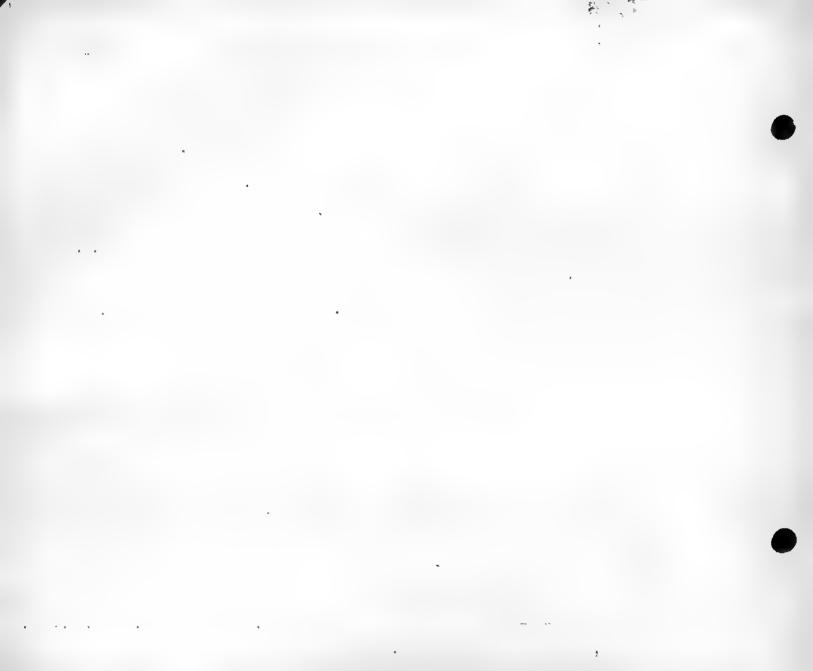
Buriel 1/16/67 Mt.Calvary Arnold Md 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE Charles C.E. Hicks . 111 Frederick.Md



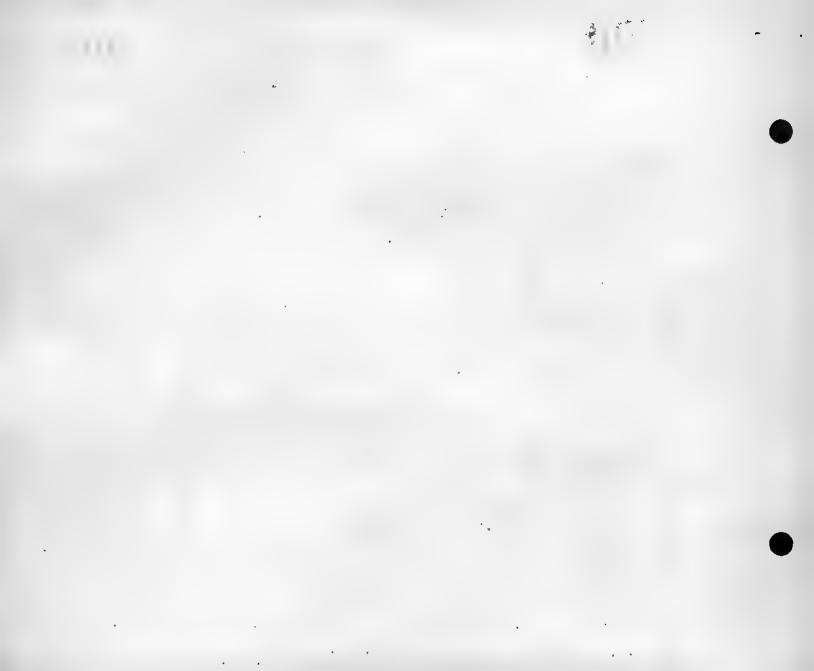
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00119 CERTIFICATE OF DEATH be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY signed by the attending physical and campletely filled in by the fur burial-transit permit. Then please remave carban papers. Pages 1 burial, crematian, ar remaval, and in any event, within 72 haurs after Anne Arundel Anne Arundel MARYLAND Marvland b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) D. O. A. RURAL - Annapolis Annapolis d. NAME OF JOSP TAL OR INSTITUTION. (If not in hospitol, give street oddress)
Inne Arundel General Hospital d. STREET ADDRESS e IS RESIDENCE ON A FARM? Rt-1, Box-622. NO FT YES NAME OF Middle 4. DATE Month First Year Doy DECEASED (Type or pnnt) Winifred HEARD January 19 67 DEATH S. SEX 6 COLOR OR RACE DATE OF BIRTH AGE (In years IF JNDER I YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED Jast, birthdoy) Months Doys Hours WIDOWED DIVORCED White Female 100 JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT (County & State, or foreign country) during mest of working life, even if retired) INDUSTRY, COUNTRY? requires that the death certificant HOUSEWIF OM 8 13. FATHER'S NAME attending privalent LLIAM 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dates of service) # 2 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o' DUE TO Conditions, if any, which gave rise to immediate couse (a), **DUE TO** stoting the underlying couse to FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept of Health priar ta 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) CERTIFICATION NO X 200 ACCIDENT WAS UNDERLYING [3] 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port I, of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) (County) factory, street, office bldg. etc.) Not While at work ot work 21. I certify that (1) the chessital) attended the deceased fram. 19 (that (1) true) last be retained 19.66, and that death accurred fram causes and an the date stated above. saw the deceased alive an_ 220 SIGNATURE 22b. DATE SIGNED MED.
DIRECTOR ATTENDING M.D 22c. PHYSICIAN'S 22d. ADDRESS Page 4 may NAME (Type) Richard I. Hochman, M.D. 59 Franklin St., Annapolis, Md. 23c. NAME OF CEMETERY OR CREMATORY 230 BJRIAL, CREMATION 23b. DATE THEREO! 23d LOCATION (City or Town) (State) CEM 2Sb. REGISTRAR'S SIGNATURI 2So. REC'D BY REGISTRAR 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF OEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 3 ta o. COUNTY o STATE b COUNTY ö Anne Arundel MARYLAND Marvland delay b CITY OR TOWN (f outside corporate mits, write RURAL and give nearest tawn) E LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate Emits write RURA, and give nearest town) and P.M3 after Baltimore Jessup d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE haurs ON A FARM? Maryland House of Correction 2836 Sixth St. State Give Pages YES NOONE after death alang with 3 NAME OF Middle First 4 OATE Lost Month Year DECEASED O.F within 7 HINKLE Jr (Type or print) HARRY W. 67 **OEATH** January 19 S SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7 MARRIED B. DATE OF BIRTH 9 AGE (In years F UNDER 24 HRS NEVER MARRIED last birthday) Months Hours Itет 18. Male White DIVORCED X Aug. 12. 1923 WIDOWED 24 hours Office 10o USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (Stote or foreign country) TOP KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? .⊑ U.S Examiner s Guard Security Maryland pencil 13. FATHER S NAME within 14 MOTHER'S MAIDEN NAME igoc B III Harry W. Hinkle Nora Bennaman PIIID 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO be executed Address ef Medical (Yes, no, ar unknown) (If yes give wor or dates of service removal. 'pending" Mrs. Nora Hinkle - 3836 Sixth St., Baltimore Yes 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH Arteriosclerotic Heart Disease. Б IMMEDIATE CAUSE (o) __ This certificate should writing the ward cremation, DUE TO Conditions, if ony, which gove (b) rise to immediate cause (o), DUE TO stoting the underlying couse burial, PART I OTHER SIGNIF CAN'T CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? please execute the certificate, YES X NO designated agent, prior to 20o. EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item IB) shauld PRIMARY CONTRIBUTING C CAUSE OF DEATH MEDICAL 20e, PLACE OF INJURY (Home, form (Stote) 20c T ME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (City or town) (County) Hour a.m. Not While factory, street, office bldg., etc.) FUNERAL DIRECTOR: Page ot work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my apin an death resulted fram Natural causes 🖈 Accident Suicide Hamicide Undetermined manner director CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE the funeral Б OEPUTY MEDICAL EXAMINER 1/18/67 **EXAMINER'S** Charles S. Petty Health NAME (Type) Address (Street, city, town, or county) 23b DATE THEREOF 230. BURIAL, CREMATION. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 0 REMOVAL (Specify) 1-21-1967 Glen Haven Memorial Pk. Ritchie Hgwy REG STRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15ME (5) George J. Gonce-4001 Ritchie Hgwy., Baltimore Marley Judge

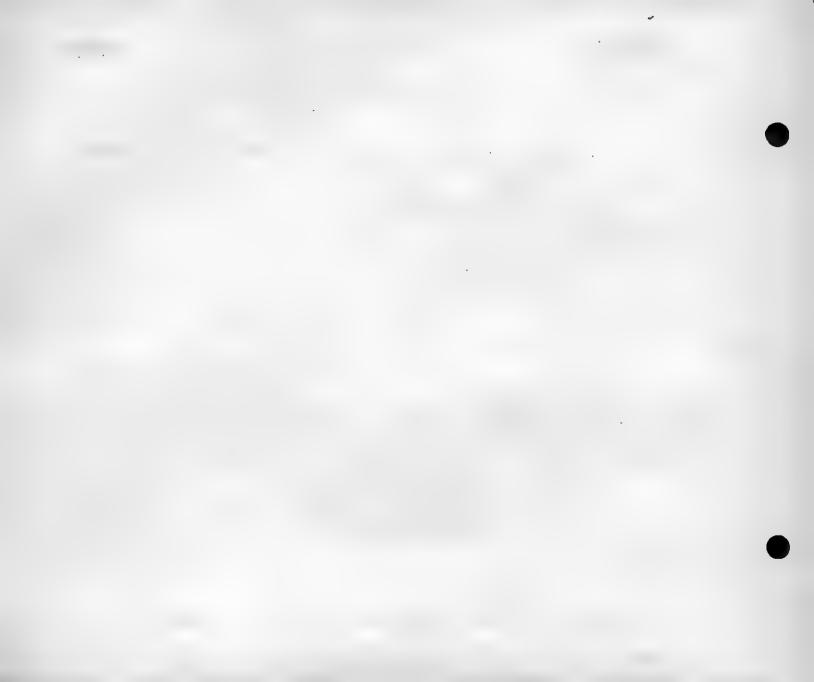


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00113 CERTIFICATE OF DEATH 00114 The law requires that the death certificate be executed within 24 hours after death. death physician and campletely filled in by the funeral en please remave carban papers. Pages 1 and oval, and in any event, within 72 haurs after death 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH a. COUNTY o. STATE b. COUNTY ANNE ARUNDET. MARYT.AND ANNE ARUNDEL MARYLAND b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) 58 DAYS RURAL- MILLERSVILLE RITRAT. CI.EN BURNIE de NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS NORTH ARUNDEL HOSPITAL RT.2 BOX 174 YES NO X 3. NAME OF Middle 4 DATE First Last Month DECEASED
(Type or print) COODIN HINSON EDWARD JANUARY DEATH S SEX 7. MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER I YEAR LIF UNDER 24 HRS 6. COLOR OR RACE NEVER MARRIED last birthdov) Days MALE DIVORCED MARCH 16.1889 WHITE WIDOWED 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done DRYCLEANING COUNTRY? during most of working life, even if retired)
CHAUFFEUR-RETIRED ALBERNARLE NOTRH CAROLINA USA 14 MOTHER'S MAIDEN NAME 13. FATHER S NAME Frank Hinson Shara (unknown WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) ((If yes give war ar dates af service) RT 2 BOX 174 **214-**01-1683 VIRGINIA GRIFFIN INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) Arterioselerosis ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by DUE TO enoselerotis Conditions, if any, which gave rise to immediate cause (o). DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO [ģ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) 20g ACCIDENT WAS UNDERLYING [be retained by the haspital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Hame, farm, (City ar tawn) (Caunty) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Manth, Day, Year Hour a.m. foctory, street, office bldg., etc.) Not While 1966 to 21. I certify that (I) (this hasertal) attended the deceased from. 100 1966, and that death accurred at 215M, from causes and on the date stated above saw the deceased alive an. 22o. SIGNATURE 22b DATE SIGNED ATTENDING PHYS. MED. DIRECTOR ADDRES 22c. PHYSICIAN'S NAME (Type) director, shauld b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) (County) 23d. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) N. Carolina Carolina Memorial Cem Concord Bùrla. Jan. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 R.V. Singleton urnie, Md. Glen



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) Anne Arundel a. COUNTY o. STATE Maryland b. COUNTY / Page 0 with the State Deportment of MARYLAND delay i b CTY OR TOWN (If outside corparate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If guts de carparate limits, write RURA, and give negrest tawn write RURAL and give pearest town)
Glen Burnie-rural Pasadena -rural 25 vrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS along with farm Rt. 10 Box 106 Lake Shore North Arundel Hospital in Item 18. Give Poges YES NO X 24 hours ofter deoth. NAME OF First Middle Inst 4 DATE Month Dov Year DECEASED 3. Bernard 17 Holmes (Type or print) DEATH 19 67 6 COLOR OR RACE B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED IX NEVER MARRIED lost birthdoy) Months Hours 5/29/1908 male white WIDOWED DIVORCED 59 58 VIS 100 LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) ofter INDUSTRY COUNTRY? word "pending" in pencil in the Chief Medical Examiner's Insurance Insurance Marvland H. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME This certificate shauld be executed within Thomas Joseph Holmes Sr. Curley IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service event within 213-28-5676 Margaret Holmes (Wife) As Above No. 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN PART DEATH WAS CAUSED BY ONSET AND DEATH Steering wheel injury of chest with transection IMMEDIATE CAUSE (o). of aorta -DHP-TO ony Conditions, if any, which gave the certificate, writing the 4 should be farwarded to 1 rise to immediate couse (a). ui puo DUE TO stating the underlying cause 0 removal, PART IF OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) 9 WAS AUTOPSY PERFORMED? CERTIFICATION YES 🚽 NO 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 1 of item 18) 3 should ō PRIMARY Tor CONTRIBUTING MEDICAL EXAMINER: driver in auto-fixed object collision CAUSE OF DEATH. cremation, CAL 20c T ME OF INJURY Month, Doy, Year 20d NIURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) WED While Not While I factory, street, office bldg., etc.) 1967 street Glen Burnie A.A. Md. 21. I certify that I taak charge of the remains described above, held an Autopsy 🛣 Inspection . Inquiry [7], and in my apinian Natural causes Accident X death resulted from. Suicide 🗍 Hamicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER K Health prior t may be re FUNERAL D SIGNATURE TO DEPUTY DEPUTY MEDICAL EXAMINER Werner U. Spitz, 1/17/67 **EXAMINER'S** M.D NAME (Type) Address (Street city, town, or county) 230 BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 50 REMOVAL (Specify) Glen Haven Mem. Glen Burnie, Md.
GISTRAR 256 REGISTRARS SIGNATURE Burial
24 FUNERAL DIRECTOR 1/20/1967 2So REC'D BY REGISTRAR VR A15ME (5) Melianley Raymond C. Fink Glen Burnie, Md. 1967 6M 1767

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission o. COUNTY b. COUNTY MARYLAND by h. CITY OR TOWN (If outside carparate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) and in any event, within 72 naurs a write RURAL and give nearest town) filled in papers. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) & STREET ADDRESS IS RESIDENCE YES NO 🔀 NAME OF remove carban Middle Last 4. DATE Month campletely DECEASED (Type or print) DEATH SEX 6. COLOR OR RACE MARRIED DATE OF BIRTH AGE (In years IF UNDER 1 YEAR NEVER MARRIED last birthday) Manths Days D1081 WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done IDb. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or fareign cauntry) during most of working life, even if retired) 056 **INDUSTRY** COUNTRY? WAN 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME MANders SOMMERS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT Address VAA 17 burial, crematian, ar re permit. (Yes, na, ar unknown) (If yes give war ar dates of service -16-738017 IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEEN signed by the burial-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital ar attending physician. DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause director, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health prior ta this certificate has been last. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a). WAS AUTOPSY PERFORMED? CERTIFICATION exemenative Oskoon thritis NO 20a ACC DENT WAS UNDERLYING [DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part I at item 18) OR CONTRIBUTING CAUSE OF DEATH hartwise was Spontamous. (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c TIME OF INJURY Manth, Day, Year INJURY OCCURRED 20e PLACE OF INJRY (Hame, farm, (City or tawn) (County) (State) Hour am. While Not While factory, street, affice bida, etc.) at wark at wark TO FUNERAL DIRECTOR: After 1966 21. I certify that (1) (this hospital) attended the deceased from 1 . ta 2, and that death accurred at P. M. fram causes and (saw) the deceased alive an an the date stated above CONATURE 22b DATE S GNED 22a **ATTENDING** STAFF M.D PHYS DIRECTOR ADDRESS ERKOUW. CEMETERY OR CREMATORY BURIAL, CREMATION, DATE THEREOF LOCATION (City or Town) (County) 1D. EUNERAL DIRECTOR 250 REC'D BY REGISTRAR 25b REG STRAR S SIGNATURE VR A15 (4) 25M 1/67

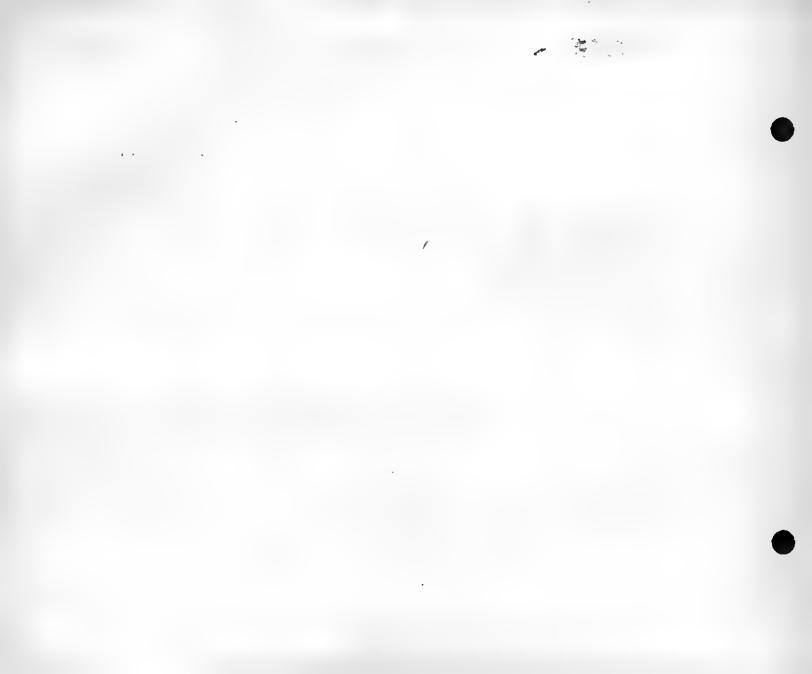


	1	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
MA		00116 CERTIFICATE OF DEA	TH /	00117	
(IVI)	1,	PLACE OF DEATH	SIDENCE (Where deceased lived, If institution	nı Residenca befora admission	
	M	e. STATE	A PULL A O B. COUNTY		
	14	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN The	TOWN (If autside corporete limits, yerra RURA.	and give negret town)	
		Write RURAL and give bearest town)	En) BURNIE (FREE	I na!	
	-	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET A		- IC DECIDENCE	
2.4	4	MODELL GENERAL B	321/	ON A FARM	
) /	3	NAME OF First Middle Last	4. DATE Month	YES NO	
		DECEASED	OF .	7 5 f 40 f 40	
	<u>-</u>	SITINGLE REPAIR HOWARD	31770	4 1967	
1	"	MARKIED NEVER MARKIED	9. AGE (In years IF UNDE		
	10	WINDOWED DIVORCED JAN 30	1924 43 yrs.		
• /	do	- USUAL OCCUPATION (Give kind of work eduring most of working life, even if retired)	2 2 1	CITIZEN OF WHAT COUNTR	
	-	flRung			
	13,	FATHER'S NAME	-33 - 3		
	-		INIE BLAND		
		WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT s, no, or unknown] [(liyesgivewerordetasofservice)]	Address		
	١.	HILDA HO	IWARD		
	П	18. CRUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).]		ONSET AND DEATH	
		PART I DEATH WAS CAUSED BY. MASSIVE CEREBRAL HE	-MORRHAGE	SUDEN	
		713 A DUE TO		2	
		Conditions, if any, which) (b) MALIGINANT HYPERTE	ENSION	JSYRS	
		geve rise to immediate cause (a), stating the underlying DUE TO		/	
		couse last (c)			
-7	ő	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TH	e terminal disease condition given in P/	ART 1(e) 19. WAS AUTOPSY PERFORMED?	
1	CAT			YES NO	
	CERTIFI	206 ACCIDENT WAS UNDERLYING [206. DESCRIBE HOW INJURY OCCURED. (Enter nature of OR CONTRIBUTING [] CAUSE OF DEATH	n ury in Pert I or Part II of item 18)		
	U	(IF EITHER, NOTIFY MEDICAL EXAMINER)			
	SA	20c. TIME OF INJURY Month, Dey, Yeer 20d, INJURY OCCURRED 20e, PLACE OF INJURY (Ho Hour e.m. While Not While fectory, street, office by		County) (State)	
	MEDIC,	Hour a.m. While Not While lectory, street, office b			
		21. I certify that (I) (this hospital) attended the deceased from	194 , to 1967	19 that (I) (we) I	
		saw the deceased alive on. JAN 7 1967, and that death occurren	d at Z.A.M. from the causes and or	n the date stated above	
		22a, SIGNATURE		22b, DATE	
		arthur Lankford &. ATTENDING PHYS	MED. STAFF DIRECTOR PHYS.	1-2 4-6 h	
		22c. PHYSICIAN'S 22d. ADDRI	:55		
1		NAME (TYPO) ARTHUR LANKFORD, JR., M. D. 1934 Mores	Main Rd Varaclema,	md. 21122	
- 1	23	BURIAL, CREMATION, 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City, town or cou	unty) (State)	
		REMOVAL Specify 1-28-1967 MOUNT CALVAN	EY ARONDEL CO	Ma.	
	24	FUNERAL DIRECTOR'S SIGNATURE BACTEDORESS Md.	Se. REC'D BY REGISTRAR 256. REGISTRAR	'S SIGNATURE	
	1		DATE JAN 27 1967 400	carles Judge	
	-				

MARYLAND STATE DEPARTMENT OF HEALTH



1/1		EPARTMENT OF HEALTH DI W. PRESTON STREET, BALTIMORE, MARYLAND 21201				
FOR STATE	00112	CERTIFICATE OF DEATH 08118				
HEALTH DEPT.	1 PLACE OF DEATH	2 USUAL RESIDENCE (Where deceased rived, if institution Residence before admission)				
5 t 8 4 4	o. COUNTY Anne Arundel MARYIAND	d STATE Maryland b. COUNTY				
and 3 to and a to and a to and a to and a to a t	b CITY OR TOWN (If autside corporate limits, C. LENGTH DE STAY IN 16	c CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town)				
after death It way delay is 8 Give Pages 1, 2, and 3 to along with farm PM3. Page with the State Department of within 72 hours after feath	write RURAL and give nearest town) Glen Burnie	Baltimore 30.4				
	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d STREET ADDRESS e IS RES DENCE On A FARM?				
Give Pages 1, and with farm the State Destroy	North Arundel General	102 E. Fort Ave. YES AD				
Page vith vith 72 1	3 NAME OF Frst Middle DECEASED Frst Middle	Lost 4 DATE Month Day Year				
er d iive ng v ng thu	(Type or print) Jordan H	utto DEATH L 8 1967				
24 hours after death If Jin Item 18 Give Pages 1, r's Office along with farm as I and 2 with the State Degny event within 72 hours on y event within 72 hours	5 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED	B DATE DF BIRTH 9 AGE (In yeors IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min				
thin 24 hours are and in Item 18 miner's Office all pages land 2 will in any event w	male white WIDDWFD DIVDRCED 100 USUAL DCCLPAT DN (G ve k nd of work #lone 100 KIND DF BUSINESS DR	11 BIRTHPLACE (State or foreign country) 12 CIT.ZEN OF WHAT				
1 ho lite Offi lar	during mass at working life, even if retired	COUNTRY				
K-1	13 FATHERS NAME	14 MOTHER'S MAIDEN NAME				
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and wit	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17	INFORMANT Address Address				
cute ng ng rmit aval,	(Yes, no or unknown) (If yes give war or dates at service)	121, Educ Hutto-				
exe endii Me t pe t pe	(Yes, no or unknown) (If yes give war or dates at service) Conditions, if ony, which gave are properties at a mediate cause (o), and the properties at a mediate cause (o).					
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sho e w a th a th burii	Conditions, if ony, which gave (b)					
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certifical writing arwarded arwarded used as c		THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a) 19 WAS AUTOPSY				
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MINER: This the certificate, 4 shauld be four files. It files. Should be to 3 should be to gent, priar fall.	200 EXTERNAL CAUSE WAS 200 DESCR BE HOW INJURY OCCURRED PRIMARY 120 or CONTRIBUTING □	(Enter nature of injury in Port I or Port II of item 1B.)				
Cerrandles.						
AM E 4 Solution of the state of	20c TIME OF N.JRY Month, Doy, Yeor Hour o.m. 3:00 RNR 1 8 1967 20d IN.JRY OCCURRED 20e PLACE OF INJURY (Home, farm, fortony, street, affice bldg, etc.) water 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, fortony, street, affice bldg, etc.) water Annapolis A.A. Md					
Pog Pog (ar.)	21. I certify that I took charge of the remains described above, h	etd an Autopsy 🗷 , Inspection 🔲 , Inquiry 🔲 , and in my opinion				
MEDICAL EXA please execute il director. Poge retained far you I DIRECTOR: Pag its designated	death resulted from: Notural couses 🔲, Accident 🗷, Su	cide, Homicide, Undetermined monner				
MED please directorin DIRE	ACTUAL MILL OF G	CHIEF MEDICAL EXAMINER 22. DATE SIGNED				
Y P P ad a p a region of the r	SIGNATURE // Wat 1	M.D ASSISTANT INCUICAL EXAMINER (24)				
IO DEPUTY MESTA. In cessary, please ex the funeral, pleastor. 5 may be refained for EUNERAL DIRECTOR. Health or its design.	EXAMINER'S Werner U. Spitz/M.D.	DEPUTY MEDICAL EXAMINER 1/9/67 Address (Street, city, tawn, ar county)				
D DE	23g BURIA, CREMATION 23b DATE THEREOF / 23c NAME OF CEMETERY OF	CREMATORY 23d LOCATION (City or Town) (Caypty) (State)				
E	- Burus 1/12/67 Baltonal	end Com. 550/ mederick-actil.				
VR ATSME IS	24 SUNERAL DIRECTOR	250 REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE				
6M 1/66	John J. Sanan Holl The, 3 to	eans DATE 1111 10 1967 Julianies Julga				



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral death. and deal PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY completely filled in by the vecarbon papers. Pages 1 event, within 72 hours after Anne Arundel MARYLAND Marvland Anne Arundel CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Glen Burnie Millersville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Arundel Hospital NO X Rol Park Trailer Willageres within 3. NAME OF Middle Last DATE Month Year DECEASED OF C. David 1967 Ingraham (Type or print) DEATH Jan. executed 6. COLOR OR RACE | 7. MARRIED 5. SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months I Days Hours I Min. 8. DATE OF BIRTH NEVER MARRIED any Male White WIDOWED [DIVORCED T 10-10-66 = 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRT HPLACE (County & State, or foreign country) CITIZEN OF WHAT 12. þ during most of working life, even if retired) INDUSTRY COUNTRY? Maryland - Pall Pety None None certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME David L. Ingraham Bovce MZ eenev 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, or unkown) | (If yes give war or dates of service) no cremation. None David Lee Inoraham none (Father) Same as2 been signed the burial-transit is to burial, cremat CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: VAL PNEUMONITIS ER 5 SEVERAL AMMEDIATE CAUSE (a) HOURG DUE TO Conditions, If any, which gave rise to Immediate DUE TO cause (a), stating the prior underlying cause last. has 98 CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health PERFORMED? certificate NO [YES this cerum detached for 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (State) 20f. (City or town) (County) be de State factory, street, office bldg., etc.) Hour a.m. After While Not While p.m. at work at work prino DIRECTOR: Jage 3 should liled with the 21. I certify that (1) this hospital) attended the deceased from... 19 that (I) (we) last and that death occurred at 8:554M. from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. page M.D. DIRECTOR FUNERAL 22c. PHYSICIAN'S 22d. ADDRESS director, p should be f NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) REMOVAL (Specify) 13.1967 Buria Jan. Meadowridge Mem. Park Howard 24. FUNERAL-DIRECTOR ADDRESS REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 25a. VR A15 (4) Funeral Sinóleton Home MHDATE 20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00119 CERTIFICATE OF DEATH 00120 PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after deoth 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Anne Arundel Anne Arundel MARYLAND Marvland ician and completely filled in by the fur lease remove carbon papers. Pages 1 and in any event, within 72 haurs after b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)

Annapolis c. CITY OR TOWN (If autside carporate limits, write RURAL and give negrest town) c LENGTH OF STAY IN 16 RURAL - Pasadena. 35 min. d. NAME DE HOSPITAL OR INSTITUTION (If not in haspital, give streat address)
(Expired in Emergency Room)
Anne Arundel General Hospital e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Rt-1. Box-208 NAME OF Middle 4. DATE Month Last First DECEASED OF DEATH JANSSENS 26 19 67 January Woodruff (Type or print) Amv IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 8. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** last birthday) Manths Days Hours White Female WIDOWED DIVORCED Oct. 20, 1894 10a USBAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired)

SECRETTERY NDUSTRY BALTO 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME WESCO WOODRUFF 1S WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) ((If yes give war ar dates at service) 16. SOCIAL SECURITY NO. INFORMANT Address signed by the other buriol-tronsit perm buriol, cremation, o 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital or attending physician. DHE TO Canditians, if any, which gave rise ta immediate cause (a). DUE TO stating the underlying cause os the **DIRECTOR:** After this certificate has been of Health prior to WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) use NO TY YES for 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 11 of Item 18.) 20a ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Hour a.m. Not While ATTENDING at wark 21. I certify that (I) (this kession) attended the deceased from 1966 to 19 2 and that death accurred at saw the deceased alive on. M. from causes and an the date stated above 22b DATE SIGNED 22a. SIGNATURE MED. DIRECTOR PHYS 22d, ADDRESS 22c. PHYSICIAN'S **TO FUNERAL** Richard I. Hochman, M.D. 59 Franklin St., Annapolis, Md. NAME (Type) 23d LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL, CREMATION, 23b DATE THEREOI (County) MOVAL (Specify) ORSEY EADOWRIDGE 25b REGISTRAR S SIGNATURE REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Chargemen



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00120 00121 completely filled in by the funeral sove carbon papers. Pages I ond lease remove carbon papers. Pages I and a ond in any event, within 72 hours offer Leath stote be executed within 24 haurs after deoth 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) PLACE OF DEATH b. COUNTY o. COUNTY n. STATE MARYLAND c LENGTH OF STAY IN 16 c CITY OR TOWN outside corporate limits, write RURAL and give neorest town) CJTY OR TOWN (If outside corporate limits, d STREET ADDRESS IS RESIDENC NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address) ON A FARM? Middle NAME OF DATE Month Year Lost please remove carbon DECEASED OF DEATH 19 Type or print AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE NEVER MARRIED 7. MARRIED birthdoy) Months Doys Hours DIVORCED WIDOWED 12. CITIZEN OF WHAT TOB. KIND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life_even if retired) INDUSTRY 13 FATHER'S NAME burial, cremation, ar removol, Then I Address (Yes, no, or unknown) [If yes give wor or dates of service] INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) 3nd (c).) ONSET AND DEATH burial-tronsit PART I. DEATH WAS CAUSED BY: ulcunous IMMEDIATE CAUSE (o) signed by Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate hos been d for use as the of Health prior to lost. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOPSY PERFORMED? MEDICAL CERTIFICATION NO OF 205 DESCRIBE HOW INJUST OCCURRED. (Enter noture of Injury in Part 1 or Port /I of item 18) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20e PLACE OF INJURY (Home, form, 20f. (County) (Stote) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year Hour o.m. foctory, street, office bldg, etc.) Not While at work , 1962, that (I) (we) last 21 | certify that (1) (this hospital) oftended the deceased fram. 19<u>67</u>, ta. 2 19 67, and that deoth occurred ot/0:30 P. M, from causes and an the date stated above. saw the deceased alive on 22b. DATE SIGNED 220. SIGNATURE DIRECTOR PHYS M.D. 22d. ADDRESS 22c, PHYSICIANS NAME (Tope) director, should be 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) 23b. DATE THEREOF BURIAL, CREMATION, 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 DATE



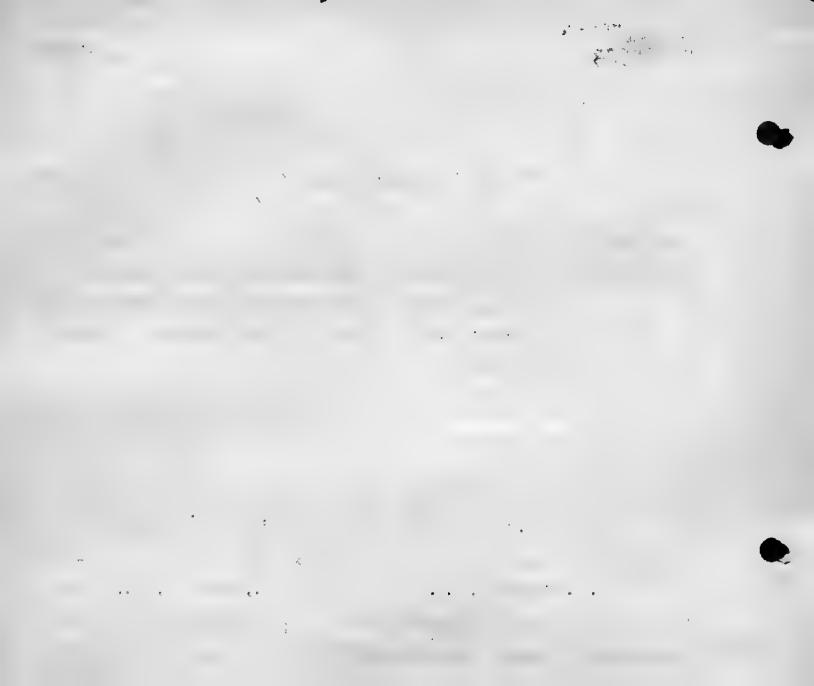
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPTA PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, funstitution Residence be a. COUNTY o. STATE b COUNTY Anne Arundel Anne Arundel Maryland MARYLAND b CITY OR TOWN (if autside corporate timits, write RURAL and give nearest town) c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 Glen Burnie Jessup d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RES DENCE ON A FARM? miner's Office along with farm pencil in Item 18. Give Pages 1, Box 46A Holliday Mobile Estates No IX North Arundel General Hospital 3. NAME OF 4 DATE Month Dov DECEASED ST. DEATH 10 (Type or print) CLARENCE JOHNSON 19 67 IF UNDER I YEAR I IF UNDER 24 HRS 7. MARRIED 6 COLOR OR RACE 8. DATE OF BIRTH 9 AGE (In years NEVER MARRIED Months Male White WIDOWED Dec. 11,1923 DIVORCED 11 BIRTHPLACE (Stote or foreign country) 10o USUA, OCCUPATION (Give kind of work done 10b. KIND OF BESINESS OR 12 CITIZEN OF WHAT during most of working ife, even if retired) Self-Empl. Baltimore, Md. Gas Sta tion Operator 13. FATHER 5 NAME 14. MOTHER'S MAIDEN NAME Anna V. Davis Norman L. Johnson 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address pending" i (Yes, no, or unknown) (If yes, give war or dates of 217/14/6134 Mrs Eleanor G. Johnson Same as # 2 18. CAUSE OF DEATH (Enter only one couse per line for (o) (b) and (c)) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) Arteriosclerotic cardiovascular disease DUE TO Conditions, if ony, which gove nse to immediate couse (o), DUE TO stoting the underlying couse crematian, ar removal, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(o) 49 WAS AUTOPSY PERFORMED? Exertion during scuffle and apparent neck injury NO F 200 EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of Item 18.) 3 should Died about 15 minutes after scuffle CAUSE OF DEATH MEDICAL 20d NJURY OCCURRED 20f (City or town) 20c T ME OF INJURY Month, Doy, Year 20e PLACE OF INJURY (Home form (County) (State) 0-8:30 pm 1 10 19 67 While NorWhile Home & Street may be retained for your FUNERAL DIRECTOR: Page Glen Burnie A.A. 21. I certify that I took charge of the remains described above, held an Autopsy 🔀, Inspection 🗍, Inquiry 🗍, and in my apinion deoth resulted from. Natural couses ... Accident ... Suicide ... Hamicide X. Undetermined manner 5 may be retaine
TO FUNERAL DIREC
Health prior ta b CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASS STANT MEDICAL EXAM NER X SIGNATURE DEPUTY MEDICAL EXAMINER Rudiger Breitenecker, M.D. 1/11/67 Address (Street, city, town, or county) NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION 23d. LOCAT ON (City or Town) (County) REMOVAL (Specify) Glen Haven Mem'l Park Glen Burnie, Md. Jan. 14, 1967 250 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR **ADDRESS** VR A15ME (5) Ocharles R.V. SINGLETON GLEN BURNIE.

tems 18-21 Film 385 1-2 MARYLAND STATE DEPARTMENT OF HEALTH



301 W. PRESTON STREET. BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS. CERTIFICATE OF DEATH funeral should 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) e. COUNTY b. COUNTY MARYLAND CITY OR TOWN (if outside corporate c. LENGTH OF STAY IN 16 ill outside corporate timits, write RURAL and give neerest town In hospital, give street address! e. IS RESIDENCE ON A FARM? YES NO 3. NAME OF DATE DECEASED OF (Type or print) DEATH AGE (In Years | IF UNDER 1 YEAR IF UNDER 24 HRS MARRIED V and last birthday) Months | Deys 106, KIND OF BUSINESS OR INDUSTRY OF WHAT COUNTRY? ring most of working life, even if retirad) Then please MER'S MA DEN NAME ARMED FORDEST (If yes give wer or detes of service) (Yes, no, or unknwn) 18. CAUSE OF DEATH (Enter only one cause per line for (5), ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE [6] Arteriosclerotic Hypertensive Cardio Vascular l貴 years DUE TO Disease Conditions, if any, which geve riss to immediate cause DUE TO (e), stating the underlying cause lest. PART I., OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 at . 19. WAS AUTOPSY CERTIFICATION as o PERFORMED? NO X 20s. ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20e, PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED I 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not While Hour m.m. at work at work 0.10 21. I certify that (I) (this hospital) attended the deceased from JULY. 10 Jan. 26 saw the deceased alive on Jan. 26 22b. DATE SHONATURE **ATTENDING** STAFF death. Page.
TO FUNERAL
director, page 3
be filed with th PHYS. DIRECTOR PHYS. 22d. ADDRESS Richardson. M.D. 110 Clay St., Annapolis, Md., 23a. BURIAL, CREMATION. NAME OF CEMETERY OR CREMATORY 25a. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE VR A15 (4)

physician



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00124 00123 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. and completely filled in by the funeral premare carban papers. Pages 1 and 2 in any event, within 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) o COUNTY a. STATE MARYLAND b CITY DR TOWN (If autside carparate limits, c LENGTH DE STAY IN 16 CITY DR TOWN (If autside carparate limits, write RURAL and give nearest town) wrde RuRAL and a ve negrest town) timore Burne d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Anthony Ave. Hospital NO NAME OF Middle 4. DATE First Lost Month Year DECEASED Kaumond ones (Type or print) DEATH 19 S SEX 6. CDLOR OR RACE DATE OF BIRTH AGÉ (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** (19st b rthdoy) Months Dovs white male WIDOWED DIVORCED signed by the attending physician and burial-transit permits. Then lease remburial, crematian, occupabal, and in an 10b. KIND OF BUSINESS OR 10a USUAL OCCUPATION (Give kind of work dane 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY Maruland ompan Hartin 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Anna Raboro 17. INFORMANT Address 16 SOCIAL SECURITY NO (Yes, no ar unknown) (If yes give war at dates af service) verett Bailer 600 1101 INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause as the priar tal O FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT, RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) of Health NO YES jo 200. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part) or Part II of Item 18.) NOF detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year factary, street, affice blda., etc.) Nat While ot work at work be retained by 21. I certify that (I) (this haspital) attended the deceased fram 19. , that (I) (we) last director, page 3 shauld shauld be filed with the saw the deceased alive an and that death accurred at M, fram causes and an the date stated above. 22a SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL Page 4 may 8 NAME (Type) 20 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION (County) (Stote) REMOVAL (Specify) taith jardens of buria 256 REGISTRAR'S SIGNATURE 2Sg. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Ruck Inc Baltimore. Md.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH should executed within 24 hours after 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decresed lived, If institution: Residence before admission e. COUNTY by the land 2 death. b. COUNTY ANNE ARUNDEL MARYLAND PRINCE GEORGES filled in by the Pages 1 and 2 MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, 45 Min Laurel d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? completely 184 Ethel Drive, Apt Kimbrough Army Hospital papers. NO X 3. NAME OF DECEASED 72 4. DATE Middle Day OF within (Type or print) BERTRAN JOSEPH DEATH JANUARY 67 19 carbon 6. COLOR OR RACE 7. MARRIED THEYER MARRIED and DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lest birthdey) Months April 1913 MALE CAU WIDOWED [DIVORCED I physician гещоче 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY dona during most of working life, even if retired) San Francisco, Calif Retired serviceman U.S.Air Force USA please .= 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME affending Melville M. Joseph Jessie Brown Fhen 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Alexander . Va. (Yes, no, or unkown) (If yes give war or detes of service Aug Mildred C. Joseph . 6621 Wakefield Drive ۵ 18. CAUSE OF DEATH [Enler only one cause per line for (e,, (b,, end (c).) INTERVAL BETWEEN ONSET AND DEATH has been signed PART I. DEATH WAS CAUSED BY, Acute myocardial infarction hrs IMMEDIATE CAUSE (a) cremation. **burial-transit** affending DUE TO Arteriosclerotic Heart Disease Conditions, if any, which geva rise to immediate causa DUE TO (e), stelling the underlying the be retained by the hospital or After this certificate prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e), 19. WAS AUTOPSY CERTIFICATION PERFORMED? N N NO detached for 206. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Pert I or Pert II of item 18.) Health (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Yaar 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Homa, farm,) (County) (State) ŏ fectory, street, office bldg., etc.) Hour e.m. While Not While DIRECTOR at work p.m. pe 197, to 15 Jan 19 67 that (4) (we) last 21. I certify that 11) (this hospital) attended the deceased from 15 Jan pluods19.67, and that death occurred at p.M. from the causes and on the date stated above. saw the deceased alive on... may 22e. SIGNATURE 22b. DATE 15 Jan 67 ATTENDING death. Page 4 MED STAFF PHYS. DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type)CARL S. ROSEN, CPT,MC rector, KIMBROUGH ARMY HOSP, FT @ EO G MEADE, MD 23a. BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (Stete) O To A REMOVAL (Specify) BUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR + 25b. MEGISTRAR'S SIGNATURE VR A1S (4) 2DM 5-63



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00125 00126 ATTENDING PHYSICIAN: The law requires that the death certificate be Executed within 24 hours after death ician and completely filled in by the funeral lease remove carbon papers. Pages 1 and, and in any event, within 72 hours after deaf PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE Maryland 5. COUNTY Arundel Anne MARYLAND Anne Arundel b CITY OR TOWN (If outside corporate limits. CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) write RURAL and give nearest town)
Annapolis RURAL. 1 hr. 15 min. Tracy's Landing d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RES DENC ON A FARM? Anne Arundel General Hospital NO D 3. NAME OF First Lost 4 DATE Year DECEASED JOYCE Lillian 67 Alice (Type or print) 19 DEATH 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED X AGE (in years NEVER MARRIED birthday) Months "hite 3-31-10 Female WIDOWED 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY 13 FATHER S NAME 14 MOTHER'S MAIDEN NAME cremotion, or removal INFORMAN WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. signed by the attend (Yes, no, or unknown) lift was give wor or dates of service RACCYS LANDING 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c))
PART 1 DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) by the hospital or attending physician. DUE TO Conditions, if any, which gave nse to immediate cause (a), DUE TO for use as the b Health priar to b stoting the underlying couse hos been WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO this certificate 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 2Gc TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, office bldg., etc.) O FUNERAL DIRECTOR: After 67 10 Jan. 6 21. I certify that (1) (this hospital) attended the deceased from dan.o be retained director, page 3 snavra should be filed with the Jan.6 19 67, and that death accurred of 3:30PM, from causes and an the date stated above. saw the deceased alive an 22a SIGNATURE 22b. DATE SIGNED M.D. 22d. ADDRESS 22c PHYSICIAN'S Annapolis NAME (Type) 236 DATE THEREOF BURTAL, CREMATION, NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) 24 FUNERAL DIRECTOR **ADDRESS** 250 REC'D BY REGISTRAR 25h REGISTRAR'S SIGNATURE harles

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06126 CERTIFICATE OF DEATH 00127 and completely filled in by the funerol remove carbon popers. Pages 1: ond 2 no now event, within 72 hours, after death. be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b COUNTY Anne Arundel Anne Arundel MARYLAND CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, and give nearest town) Odenton vears e. IS RESIDENCE ON A FARM? YES NO d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Harding St Knellweed Maner Nursing Heme ottending physician and completely fi permit. Then please remove carbon 3 NAME OF First Middle Last 4. DATE Year DECEASED January 29. 67 Helen M. Kaiss 19 DEATH (Type or pnnt) AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH rost birthday) March 30, 1891 Davs Hours Female Caucasian Lond in any WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY Salem New Hampshire
14. MOTHER'S MAIDEN NAME USA Housewife 13. FATHER'S NAME The low requires that the death certiff or removal George W. Pierce Clara A. Armour IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT King Street (Yes, no, or unknown) (If yes give wor or dotes of service) Kenneth P Daly (sen) Cambridge, Massachusetts 214-54-1680 cremotian. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the buriol-tronsit p ONSET AND DEATH Paeumenia IMMEDIATE CAUSE (6) Page 4 may be retained by the hospital or attending physicion. **DUE TO** Conditions, if any, which gave rise to immediate couse (o), **DUE TO** stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been prior to for use os the WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION NO Arteriescleresis, general and cerebral 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 1B.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d INJURY OCCURRED 20r. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While OR ATTENDING of work ot work 3 should be 21. I certify that (I) (this haspital) attended the deceased from June 30, 185, to 2 anuary 29 19 67, that (I) (we) last saw the deceased alive an January 8, 19 67, and that death occurred of 10:15 M, from causes and on the date stated above. 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. January 291967 ATTENDING M.D. DIRECTOR director, page should be filed 22d. ADDRESS South River Medical Center 22c. PHYSICIAN S NAME (Type) Edgewater, Maryland 21037 Charles W. Kinzer, M. D. 23d. LOCATION (City or Town) (Stote) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) 23o. BURIAL, CREMATION REMOVAL (Specify) Md. Eniphany Episcopal Odenton Cem. Jan. 30, 1967 2So. REC'D BY REGISTRAR 25h REGISTRAR'S SIGNATURE Hopping VR A15 (4) 20 M 1/66 DATE Hopping Funeral Home Annandlis



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00127 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00128 FOR STATE HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased ived, it institution. Residence before admission) delay 1s nd 3 ta Page VIVLO3 o o STATE Anne Arundel Maryland MARYLAND Anne Arundel Department b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (flouts de corporate limits, write RURAL and give nearest town) P.M.3 write RURAL and give nearest town) Millersville Glen Burnie Mi mites: d NAME OF HOSPITAL OR INSTITUTION (if not in hospita, give street oddress) d STREET ADDRESS S RES DENCE ON A FARM? haurs Rt. 424 and Patuxent River. 103 Crain Highway Item 18. Give Pages YES NO 5 haurs after death. 3 NAME OF with the Sta within 72 | First Middle 4 DATE . ast DECEASED **EDGAR** (Type or print) KEMP DEATH January 19 67 S SEX 6 COLOR OR RACE B DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED 24 vrs Months Doys Hours Male White WIDOWED DIVORCED 18 May 1942 event 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or fore an country) 12 CT ZEN OF WHAT during most of working life, even if retired)

Painter INDUSTRY COUNTRY? Baltimore Maryland
14. MOTHERS MAIDEN NAME USA .3 FATHER S NAME This certificate shauld be executed within penci _ Arthur L. Kemo. Sr and Alice May Trail 15 WAS DECEASED EVER IN U.S ARMED FORCES? 16 SOCIAL SECURITY NO **17 INFORMANT** Address or remayal. (Yes, no, or unknown) (If yes give wor or dates of service) No 214-40-1341 Mrs. Connie Kemp. sane as 2 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART f DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) Gunshot Wound of Chest. used as a burial-trai burial, cremation, o writing the ward DHE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? prior to YES X NO 20o EXTERNAL CAUSE WAS 20b DESCR BE #OW INJURY OCCURRED (Enter nature of injury in Part I or Port I of Item .8) PR MARY DO OF CONTRIBUTING Accidental discharge of rifle while target shooting. MEDICAL EXAMINER: CAUSE OF DEATH agent, Ś 20d NJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) 20c T ME OF INJURY Month Dov. Year (County) (Stote) Not While HOUXHIKX foctory, street, office bldg etc) 5 may be retained for your O FUNERAL DIRECTOR: Page 1/22 1967 A .A . Md. ot work 21. I certify that I taak charge of the remains described above, held an Autopsy [x], Inspection Inquiry and in my opinion the funeral director. 5 may be retained f Suicide | death resulted fram. Natural causes Accident x Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY 1/23/67 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health Charles S. Petty NAME (Type) Address (Street, city, town, or county) 230 BURIAL, CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify)
Burial 25 Jan. 1967 Glen Haven Memorial Glen Burnie 24 FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15ME (5) 26 1967 6M 1/66 Kirkley Funeral Home, Glen Burnie, Mi.



_	00128		CERTIFICATI	OF DEATH		00123
1.	PLACE OF DEATH					If institution, Residence bafore a
	Anne Arundel		MARYLAND	° Maryland		nne Arundel
	b. CITY OR TOWN (if outside of write RURAL and give near	orporata limits,	c. LENGTH OF STAY IN 16	1		rite RURAL and giva naarast low
	Ft G.G. Meade,	Maryland	DOA	Ft Geo G.	Meade, Maryl	land
	d. NAME OF HOSPITAL OR IN	STITUTION (if not in h	ospital, giva straat addrass)	d. STREET ADDRESS		e. IS R
	Kimbrough Army	Hospital		1858-E Pat	ton Drive	YES
3.	NAME OF DECEASED	First	Middla	Last	DATE Mo	•
		a Levette	King		DEATH Janu	uary 1 19-
	SEX 6. COLO	R OR RACE 7. MARE	RIED NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In yaa last birthday	IF UNDER 1 YEAR IF UNDER
1	Female Neg	ro widov	VED DIVORCED	21 October 196	6 2 mo. yrs	Months Days Hours
10	s. USUAL OCCUPATION (Give	kind of work 10b.	KIND OF BUSINESS OR INDUST	RY 11 BIRTHPLACE (County	& State, or foreign countr	ry) 12, CITIZEN OF WHAT
-	None	avon il telliedi	None	Ft Geo G. Me	eade, Maryla	and USA
13	FATHER'S NAME			14. MOTHER'S MAIDEN NA		
	Hebert King			Odessa L. Dra	ake	
15	. WAS DECEASED EVER IN U.S.	ARMED FORCES? 1	6. SOCIAL SECURITY NO. 17.		1858-E Patto	m Dr
111	NO N/A	al Ol delas disarvica)	None He	ebert Kimg(F)		
_	18. CAUSE OF DEATH (Er	ntar only ona cause pe	r line for (a), (b), and (c),]			INTERVAL BE
	PART I. DEATH WAS CA	UISEN BY.	/ Tidd/2/4/			ONSET AND
	IMMEDIAT	E CAUSE (a) Cr:	Lb Death Arenar	ng autopsy /		
	MMEDIAT 772	E CAUSE (a) Cr	ib Death Arenaz	dg/Autopsf//		
	Conditions, if any, which	DUE TO	ib Death Arenaz	ng autopsy /		
	IMMEDIAT Conditions, if any, which gave rise to immediate cause	DUE TO	ib Death Arengi	ag Autopsy /		
	IMMEDIAT	DUE TO (b) DUE TO	ib Death Arengz	ng Autopsf/		
NC	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) DUE TO (c)			al disease condition o	GIVEN IN PART I(a) 19. WAS
ATION	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) DUE TO (c)			al diséase condition g	GIVEN IN PART I(a) 19. WAS A PERFO
TIFICATION	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFIC. 20e. ACCIDENT WAS UNDER	DUE TO (b) DUE TO (c) ANT CONDITIONS CO		OT RELATED TO THE TERMINA		YES X
CERTIFICATION	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFIC.	DUE TO (b) DUE TO (c) ANT CONDITIONS CO	DNTRIBUTING TO DEATH BUT N	OT RELATED TO THE TERMINA		YES X
_	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFIC. 20e. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL	DUE TO (b) DUE TO (c) ANT CONDITIONS CO SETTING [] 20b, 1 OF DEATH EXAMINER; nih, Day, Yaar 200	DITRIBUTING TO DEATH BUT N DESCRIBE HOW INJURY OCCURI	OT RELATED TO THE TERMINA RED. (Entar nature of injury in P ACE OF INJURY (Homa, farm,		YES X
	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFIC. 20c. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mo Hour a.m.	DUE TO (b) DUE TO (c) ANT CONDITIONS CO LYING [] 20b. 1 OF DEATH EXAMINER; nih, Day, Yaar 20; Wh	DISCRIBE HOW INJURY OCCURI	OT RELATED TO THE TERMINA RED. (Entar nature of injury in P	Part (or Part II of Jam 18.)	PERFO YES 🔀
_	Conditions, if any, which gave rise to immediate causa (a), stating the underlying cause last. PART II. OTHER SIGNIFIC. 20e. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mo Hour a.m., p.m.	DUE TO (b) DUE TO (c) ANT CONDITIONS CO SLYING [] 20b. I OF DEATH EXAMINER; nih, Day, Yaar 200 Wh 19	DISCRIBE HOW INJURY OCCURION INJURY OCCURION INJURY OCCURRED 20a. PL fair ork at work at work at work 1	OT RELATED TO THE TERMINA RED. (Entar nature of injury in P ACE OF INJURY (Home, ferm, ctory, straet, office bldg., etc.)	20f. (City or town)	YES YES (County)
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_	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFIC. 20c. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mohour a.m., p.m.	DUE TO (b) DUE TO (c) ANT CONDITIONS CO SETTING OF DEATH EXAMINER; nih, Day, Yaar 19 20b. 1 Wh 19 at w	DESCRIBE HOW INJURY OCCURING TO DESCRIBE HOW INJURY OCCURRED 20a. PL famile Not While at work at 16025AM, a 2003	OT RELATED TO THE TERMINA RED. (Enter nature of injury in P ACE OF INJURY (Home, farm, ctory, straal, office bldg., etc.) C. at. 1025., LJan 19	20f. (City or town) 20f. (rom the cause)	(County) (County) 120, Max (100) 15 and on the date stated
	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFIC 20s. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mohour a.m., p.m. 21. I certify that (ix (ix ix i	DUE TO (b) DUE TO (c) ANT CONDITIONS CO SETTING OF DEATH EXAMINER; nih, Day, Yaar 19 20b. 1 Wh 19 at w	DESCRIBE HOW INJURY OCCURING TO DESCRIBE HOW INJURY OCCURRED 20a. PL famile Not While at work at 16025AM, a 2003	OT RELATED TO THE TERMINA RED. (Enter nature of injury in P ACE OF INJURY (Home, farm, ctory, strael, office bldg., etc.) 2. at 1025., 1 Jan 19	20f. (City or town) 67,000andth	(County) (County) Tex, Max (XXX) Is and on the date stated
	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFIC 20e. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mo Hour a.m., p.m. 21. I certify that (X): 22e. SIGNATURE 22e. PHYSICIAN'S AME (Type)	DUE TO (b) DUE TO (c) ANT CONDITIONS CO LYING [] 20b. if OF DEATH EXAMINER; nth, Day, Yaar 20c whis hospital) after EXOTINA S. DOA	DONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED 1. INJURY OC	ACE OF INJURY (Home, ferm, tory, streat, office bldg., etc.) at 1025, 1Jan 19 ATTENDING ME PHYS. DIR 22d. ADDRESS	20f. (City or town) 20f. (City or town) 67,000andth	(County) 120c, start (20x) 15 and on the date stated 22t 1 Jan 67
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MEDICAL	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFIC 20e. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mo Hour a.m., p.m. 21. I certify that (X) (CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY MO HOUR a.m., p.m. 21. I certify that (X) (CAUSE (IF EITHER, NOTIFY MEDICAL 22c. PHYSICIAN'S NAME (Type) BURT!	DUE TO (b) DUE TO (c) ANT CONDITIONS CO LYING [] 20b. if the examiner of	DISON, CPT, MC	ACE OF INJURY (Home, ferm, ctory, streat, office bldg., etc.) ATENDING ME PHYS. DR 22d. ADDRESS Kimbrough OR CREMATORY	20f. (City or town) 20f. (City or town) 20f. (City or town) 20f. from the cause: 20f. FT GEO G. 23d. LOCATION (City,	(County) 12x, start (30x) 15x, start (30x)
MEDICAL	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFIC. 20c. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mohour a.m., p.m. 21. I certify that (b) (1) (2) (2) (2) (3) (4) (4) (4) (4) (5) (4) (4) (5) (6) (6) (6) (6) (6) (6) (6) (6) (6) (6	DUE TO (b) DUE TO (c) ANT CONDITIONS CO ELYING [] 20b. 1 OF DEATH EXAMINER; nih, Day, Yaar 20; Wh 19 at w this hospital) atte EXOTWA S. DOA ON A. JOH DATE THEREOF 19 9, 1967	DONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED to the later of the deceased with the deceas	ACE OF INJURY (Home, farm, ctory, straat, office bldg., etc.) ALLO25., LJan 19 ATTENDING ME PHYS. DR 22d. ADDRESS Kimbrough OR CREMATORY TONAL CE.1.	20f. (City or town) 20f. (City or town) 20f. (City or town) 20f. (From the cause: ECTOR PHYS. [AH FT GEO G. 23d. LOCATION (City, ARLINGTON,	(County) 12x, start (30x) 15x, start (30x)

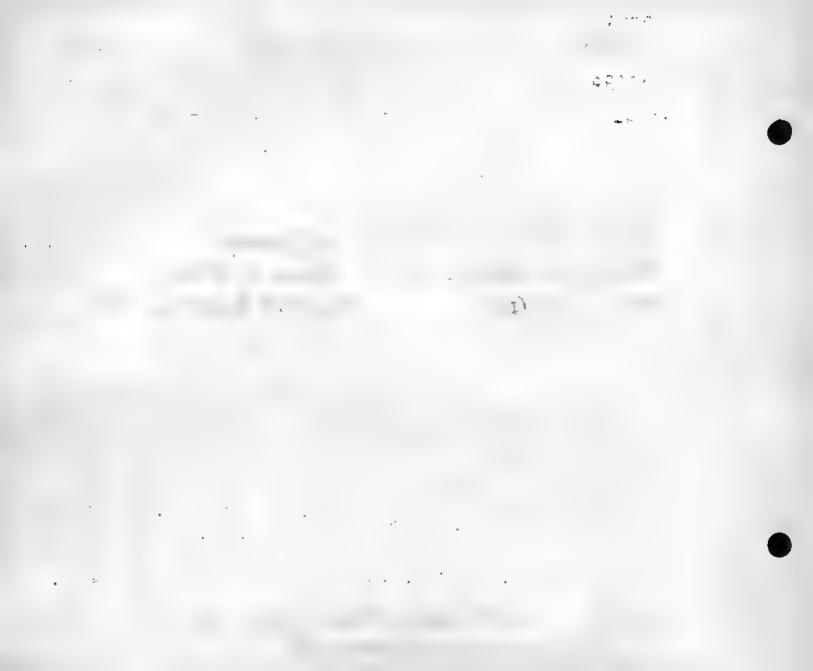


2	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21									
001	29		CERTIFICATE	OF D	EATH			0	013	0
	Arundel		MARYLAND		residence (When	e deceased li	ved, if institut b. COUI	tian Resider Minc	ATUN	odmissian) del
	VN (If outside carporate limits, and give hearest tawn)		c. LENGTH OF STAY IN 16		TOWN (If outside	e carparate lir	nits, write RU	RAL and giv	e nearest	lawn)
Nort	SPITAL OR INSTITUTION (IF not h Arundel Ho	on haspital, go spital	ve street address)	d. STREET	ADDRESS K 4 Che:	sapeak	e Tra	iler	Const	IS RESIDENCE ON A FARM? St. NO
3 NAME OF DECEASED (Type or print)	DLLIE DLLIE	i	Middle	KIN	3	DATE OF DEATH	Mon Janua	гу	Day 10	Year 19 67
s. sex Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	DIVORCED		1888	1 78	E (In years birthday) yrs	IF UNDER Months	Days	FUNDER 24 F Haurs M
quind weste Fact.	TION (Give kind of work dane king life Tvery Ethed) Ci a	n LdC	o of BUSINESS OR UNION 24		PLACE (County & Sto		country)	12. (1	TIZEN OF V	VHAT
13. FATHER'S NAM	Chris Kin	9		14. MOTH	RS MAIDEN NAMI	abeth	(Unkn	omu)		
1S. WAS DECEASED (Yes, no or unknown	EVER IN U.S. ARMED FORCES? wn) (If yes give war ar dotes of			NFORMANT	King -	- Same	Addn as #			
18. CAUSE O	F DEATH (Enter only one caus DEATH WAS CAUSED BY. IMMEDIATE CAUSE (c		a), (b), and (c).) Coro	wy	Thorns	ulos	5		INTER' ONSE	VAL BETWEE I AND DEATI
Conditions, if	any, which gove diate cause (a),	FH	fenoseles	ti'c	hear	f el	Jeas	e		
	nderlying cause DUE I	(c)								
PART II OTHE	R SIGNIFICANT CONDITIONS CO	NTRIBUTING TO	DEATH BUT NOT RELATED TO T	HE TERMINA	DISEASE CONDITI	ON GIVEN IN	PART I(a)		19. W Pi YES	AS AUTOPSY ERFORMED?
MDICAL CERTIFICATION OR CONTRIBUTION (IF FITHER, NO Page 1) 20c. TIME OF Haut	WAS UNDERLYING ING CAUSE OF DEATH TIFY MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCURRED (Enter nature	of injury in Part	I ar Part II o	item 18.)			
20c. TIME OF	INJURY Manth, Doy, Year a.m. p.m 19	20d IN. While at wark	Not While C facto		(Hame, farm, fice bldg., etc.)	20f. (Cit	y or town)	(Co	unty)	(State
21. 1 c	ertify that (I) (this hasp e deceased alive op			death a	curred at		m couses	, 19 <u>f</u>		t (I) (we)
									ATE SIGNED	
		The	1 ales, M.D	ATTENDI PHYS.	NG MED), ECTOR	STAFF PHYS.	1 0		0111
saw the	URE AN'S	Th	TALER		NG MEC DDRESS Apu	eher	STAFF PHYS. [9/1	en l	outu Mel.
saw the	AN'S JOJ ANTON 23b DATE THER		TALER 230 NAME OF CEMETERY OR OF Glen Haven A	22d A	April	elictor L	+ Rd.	wn)	(County)	Surve Mcd.



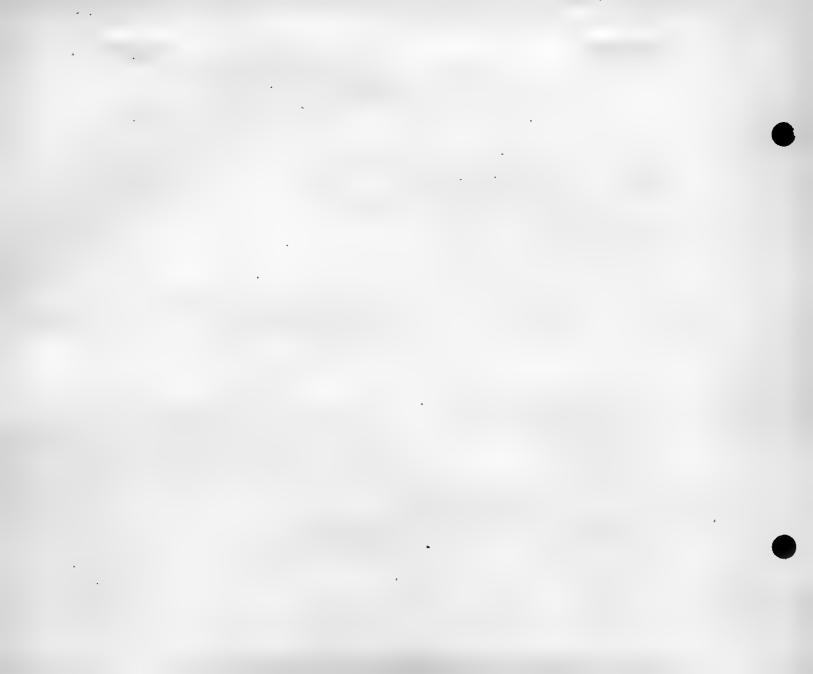
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00130 00131 CERTIFICATE OF DEATH campletely filled in by the funeral ave carbon papers Pages 1 and 3 y event, within 72 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) p. COUNTY . o. STATE b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn).

Annapolis c LENGTH OF STAY IN 16 c. CITY OR TOWN (If gutside corporate limits, write RURAL and give pegrest town) - RURAL Edgewater days d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Anne Arundel General Hospital Rt. 3. Box 759B NO X 3 NAME OF Middle 4. DATE Year Day DECEASED William Andrew DEATH January (Type or print) KNOBLOCK 19 67 SEX 9 AGE (In years nd camp 6 COLOR OR RACE 7. MARRIED X DATE OF BIRTH IF UNDER 24 FIRS NEVER MARRIED Jost birthdoy) Days Manths Haurs November 2,1896 White WIDOWED DIVORCED Male 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State or fareign country) INDUSTRICOVM 4 the attending physician of sit permit. Then please COUNTRY? U. S. 13. FATHER S NAME MOTHER'S MAIDEN NAM crematian, ar remaval, WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN yes give war at dates of service DBLOCK INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) signed by the burial-transit burial, cremati PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) by the haspital ar attending physician. DUE TO Canditians, if any, which gave rise to immediate cause (a) DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been detached far use as the te Dept. af Health priar ta last. WAS AUTOPS' PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO XT YES PHYSICIAN: 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year Haur a.m. 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form (City or town) (County) (Stote) factory, street, affice bldg., etc.) Not While OR ATTENDING 21. I certify that (1) (1894) attended the deceased from Jan. 24 19.67 to Jan. 27_, 19_67, that (1) (%) last Page 4 may be retained director, page 3 shauld shauld be filed with the Jan. 27 1967, and that death accurred at from causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22d SIGNATURE MED DIRECTOR PHYS PHYS 22d. ADDRESS NAME (Type) Stephen B. Hiltabidle, M.D. 121 Cathedral St., Annapolis, Md. 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION (State) REGISTRAR S SIGNATUR VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00131 physiaon and completely filled in by the funeral error papers. Pages 1 and 2 over, and in any event, within 72 hours after death. PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 2 USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE MARYLAND **b** CITY OR TOWN (If outside corporate I mits. c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside comporate limits, write RURAL and give negrest town) write RURAL and give nearest fown IS RESIDENCE ON A FARM? INSTITUTION (If not in hospital, give street address) YES NO 5 3 NAME OF DATE First Lost Month Dov Year DECEASED KNOWLES (Type or print DEATH IF UNDER 1 YEAR DATE OF BIRTH IF UNDER 24 HRS 5 SEX 6. COLOR OR RACE AGE (In veors 7 MARRIED NEVER MARRIED ost birthdoy) Months Hours Dovs WIDOWED DIVORCED 12 CITIZEN OF WHAT 10o LISUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY COUNTRY? HOME

13. FATHER'S NAME 14. MOTHER'S MAIDEN cremation, or remove IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dotes of service ONZENANDŁOFYCH INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) O FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be detached for use as the burnal-transit PART I. DEATH WAS CAUSED BY-Pulmonary Edema IMMEDIATE CAUSE (o) Poge 4 may be retained by the hospital or attending physician. DUE TO Generalized arteriosclerosis Conditions, if only, which gove rise to immediate couse (a), DUE TO stating the underlying couse director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to Asthma lost 19. WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) MEDICAL CERTIFICATION NO DO YES 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor 20d INJURY OCCURRED Not While foctory, street, office bldg., etc.) at work 1958 to Jan 19<u>67, that (I) (we) last</u> 21. I certify that (1) (this haspital) attended the deceased fram. 1967, and that death accurred at 8A M, fram causes and an the date stated above saw the deceased alive anJan 15 220 SIGNATURE 22b. DATE SIGNED ATTENDING PHYS STAFF PHYS. DIRECTOR L 1-16=67 M.D. 22d. ADDRESS 22c. PHYSICIAN'S Francis I. Codd M.D. Severna Park, Md. NAME (Type) 23d LOCATION (City or Town) BURIAL, CREMATION, 23b. DATE THEREOI 23c NAME OF CEMETERY OR CREMATORY (Stote) REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00133 ond 2 death, O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death the funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY **b.** COUNTY o. STATE thely filled in by the functional pages 1 of within 72 haurs after d Anne Arundel Maryland MARVIAND Anne Arundel c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 write RURAL and give nearest town) Annapolis Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS campletely filled within 38 Pinkney St. Anne Arundel General Hospital NO [YES NAME OF First DATE Day Year DECEASED KYLER (Type or print) Thomas DEATH January NUN SEX 6 COLOR OR RACE 9. AGE /In years IF UNDER 1 YEAR E UNDER 24 HRS 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 60 rthdmy) Months Dovs and in ony Male Negro WIDOWED DIVORCED June 5, 190: ond 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) **COUNTRY?** Maryland Plumbers Helper U. S. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME removal. Airy Crampton
17 INFORMANT Thomas Kyler IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dates of service 6 219-05-1006 Florence Green 817 Spa Rd Anna Md ¥-45-35-35-35-35-35-35-35 No crematian. 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), NTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (6) ONSET AND DEATH signed by the haspital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO ed for use as the L . of Health priar ta b stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS PERFORMED? NO 200 ACCIDENT WAS UNDERLYING [1] 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year (County) Hour om foctory, street, office bldg . etc.) Not While of work L of work 21. I certify that (I) (this haspital) attended the deceased from , that (I) (we) los Page 4 may be retained from causes and on the date stated above sow the deceased alive on and that death occurred at 220 SIGNATURE DATE SIGNED 22b DIRECTOR director, page 3 shauld be filed v MID 22c PHYSICIAN'S 22d, ADDRESS NAME (Type 23o. BURIAL, CREMATION 23b, DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify)

Buriel

24. FUNERAL DIRECTOR Brewer Hill A.A.C. 1-24-67 Annapolis 2Sb REGISTRAR'S SIGNATURE 2So REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Marelas C.E. Hicks, 111 Annapolis, Md

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00133 CERTIFICATE OF DEATH 00132 The law requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o. STATE Maryland o. COUNTY b. COUNTY Anne Arundel Anne Arundel MARYLAND and cappletely filled in by the I regard, arban papers. Pages in any event, within 72 hours after b CITY DR TDWN (If outside corporate limits, write RURAL and give nearest tawn) C LENGTH OF STAY IN 16 c CITY OR TDWN (If outside carparate limits, write RURAL and give negrest town) Crownsville Annapolis hour d NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street oddress) e. IS RESIDENCE ON A FARM? d STREET ADDRESS Anne Arundel General Hosp. 429 Severn View NO TH YES 3 NAME OF 4 DATE Last Month Doy Yeor DECEASED Sr. DEATH January ar remayal, and in any event, Robert Irving Lansdown 196 7 (Type or print) 6 COLOR OR RACE 9. AGE (in years IF UNDER 1 YEAR NEVER MARRIED DATE OF BIRTH IF UNDER 24 HRS. lost birthday) Months Dovs Hours WIDOWED DIVORCED Male Cauc. 30 May 1887 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT the attending physician of sit permit. Then please U. S. Navy Dept. CDUNTRY? drie past of rocking the even fretted r Washington, D. C USA 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Alexander Lansdown Carrie M. Porter IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dotes of service signed by the after burial-transit perm burial, cremation, a Ruth Wiltshire (duaghter) No same addres 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART | DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH Myocardial infarction (suspected) IMMEDIATE CAUSE (6) be retained by the hospital or attending physician. DUF TO Conditions, if any, which gove Arterioscleresis, general & coronary many years rise to immediate couse (a). **DUE TO** Page 4 may be retained by the inspired.

TO FUNERAL DIRECTOR: After this certificate has been significant, page 3 shauld be detached far use as the lighter of the light with the State Dept. at Health priar tail. stating the underlying couse WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Pulmonary emphysema, Urinary tract infection NO 20o ACCIDENT WAS UNDERLYING [1] 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) While Not While ot work ot work 1966, to22 Jan., 1967, that (I) (we) last 2). I certify that (i) (this hospital) attended the deceased from 10 June sow the deceosed olive on 3 .Tan. 1967, and that death accurred at 4 • 42M, from causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS 22 Jan. 1967 M.D DIRECTOR 22d. ADDRESSOuth River Bldg. 21037 Medical NAME (Type) Charles W. Kinzer, M. Edgewater. Maryland 23c NAME OF CEMETERY OR CHEMATORY Ft. Lincoln 230 BURIAL, CREMATION, BUREMONAL (Specify) 23d. LOCATION (City or Town) 23b. DATE THEREOF 1/25/67 (County) (Stote) Colmar Manor P. G. Md. 24. FUNERAL DIRECTOR ADDRESS 250 REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Francis Gasch's Sons Hvattsville. Md. DATE



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH and completely filled in by the funeral remave carban papers. Pages 1 and b. COUNTY a. COUNTY Maryland Anne Arundel Anne Arundel MARYLAND b CITY OR TOWN (If autside carparate imits. c CITY OR YOWN (If autside carparate limits, write RURA, and give nearest town) c LENGTH OF STAY IN 16 write RURAL and give nearest tawn) Edgewater Miller sville Md. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS NO X Knollwood Nursing Home Rt 2 Box 200 3 NAME OF Middle Last DATE Day Year physician and completely f DECEASED DEATH (Type or print) ${ t Beard}$ Lawson Nora 9. AGE (In years S. SEX 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** 8 DATE OF BIRTH lost birthday) Days Hours 1884 WIDOWED X Sept. DIVORCED white female 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10g US., AL OCCUPATION (Give kind of work done INDJSTRY COUNTRY? during most of working life, even if retired) USA own home Rockbridge, Va. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Julia F. Clark William B. Beard 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) ((If yes give war ar dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Frances L. Woolwine -same as INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the c burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. Conditions, if any, which gove rise to immediate cause (a), DUE TO far use as the b Health priar tab stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 205. DESCRIBE HOW INLURY/OCCURRED. (Eather noture of injury in Port I or Port II of item IB.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (State) 20d INJURY OCCURRED (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Nat While While at wark 19____, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased from and that death accurred at_ M, from causes and an the date stated above saw the deceased alive an 22g. SIGNATURE DATE SIGNED ATTENDING PHYS PHYS 22d ADDRESS M.D. DIRECTOR director, page 3 shauld be filed v 22c PHYSICIAN'S SEVERNA NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) 230 BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Presbyterian Cemetery Campbell Lynchburg 25b. REGISTRAR S SIGNATURS Hopping limes VR A15 (4) 20 M 1/66 HOPPING FUNERAL HOME Annapoli's.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00135 00136 hysician and completely filled in by the funeral please remove carban papers. Pages 1 and 2 ral, and in ony event, within 72 hours after deather after deather The low requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY a. STATE b. COUNTY ANNE ARUNDEL MARYLAND Maryland Anne Arundel c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside corporate I mits, c LENGTH OF STAY IN 16 write RURAL and give negrest town)
Rural - Baltimore Rural - Baltimore 25 years d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? 211 Audrey Ave. 211 Audrey Ave. YES NO EXC 3. NAME OF First Middle 4. DATE Lost Manth DECEASED ALBIN LECHOWICZ January 2h 1967 NMN DEATH (Type or print) IF UNDER 1 YEAR | IF UNDER 24 HRS S SEX DATE OF BIRTH 9 AGE (In years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED rost birthday) White Jan 19, 1893 Male WIDOWED DIVORCED 10a, USJAt OCCJPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during mast of working life, even if retired) Ship Building Poland Iron Worker 14 MOTHER 5 MAIDEN NAME 13. FATHER S NAME Pauline ----Carl Lechowicz 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give war or dates af service) 17. INFORMANT 16 SOCIAL SECURITY NO. Address Mrs. Albin Lechowicz 215-05-7407 (same) FRVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I DEATH WAS CAUSED BY. heart failure NSET AND DEATH buriol-transit IMMEDIATE CAUSE (a)_ 40361 DUE TO 4. 5. C. V. O Conditions, if only, which gove) rise to immediate cause (a), DUE TO Page 4 may be retained by the hospital or attending ID FUNERAL DIRECTOR: After this certificate has been s stating the underlying couse os the I prior to b PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? for use NO T YES 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a ACCIDENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year factory, street, office bldg., etc.) Not While at work at wark 21. I certify that (1) (this haspital) attended the deceased fram Lune 11, 1962, to Jan 27, 1967, that (1) (we) last saw the deceased alive an Jan. 24 1967, and that death accurred at 754M, fram causes and an the date stated above. 22b. DATE SIGNED 22a, SIGNATURE ATTENDING PHYS MED DIRECTOR Waho eing Jan. 24, 1967 M.D 22d ADDRESS 22c. PHYSICIAN'S LOO Crain Highway, N.W., Glen Burnie Dr. Robert Dabolins NAME (Type) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a BURIAL, CREMATION, REMOVAL (Specify) Holy Cross Cemetery Ritchie Hewy A.A.Co. Jan. 27,1967 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR YR A15 (4) 20 M 1/66 1967 George J. Gonce-4001 Ritchie Hgwy., Baltimore



1 6		M Division of STATISTICAL RESEAR		ARTMENT OF HEALTH W. PRESTON STREET, BA	LTIMORE, MARYLAND 21	201
2		00136	CERTIFICATE	OF DEATH	001	37
ate be executed within 24 haurs after death cian and campletely filled in by the funeral pase remove carban papers. Pages I, and 2 and in any event, within 72 haurs after death	1.	PLACE OF DEATH a COUNTY Anne Arundel	MARYLANO	o STATE Marvland	ceased lived, if institut on Reside b. COUNTY——	\checkmark
by the Pages		b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Crouds ville	ll days	Baltimor	parate limits, write RURAL and gi	7
Med in 194 hars.		d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give Crownsville State Hos		d. STREET ADDRESS 25 E. Jeff	erson St.	e. IS RESIDENCE ON A FARM? YES NO
i withir etely fii arban p nt, with	3	NAME OF PRIST CALVERT	Middle George	Last 4. DA Litz Of DE/	ATH 1	10 1967
xecuted I campl move c	S.	SEX 6. COLOR OR RACE 7 MARRIEO STATE Bale White WICOWED [DIVORCED 19/	DATE OF BIRTH	9. AGE (In years IF UNDER last birthday) Manths 50 yrs	Oays Hours Min.
certificate be executed within 24 hang physician and campletely filled in the Teen blease remove carban papers.	dur	ing most of warking life, even if retired) (NO	O OF BUSINESS OR USTRY	11. BIRTHPLACE (County & State, of Maryland	or fareign country) 12. (ITIZEN OF WHAT OUNTRY? USA
G physical p			David Cr.CUDINA NO. 17. IN	14. MOTHER'S MAICEN NAME WOLFE IFORMANT	Address	
he deoth ce a attending permit. The	15 (Y	es, no, or unknown) (If yes give wor or dotes of service)	6-01-8467 Ho	espital Record		AMERICA DEVICES
that the in. by the cansit p		18. CAUSE OF DEATH (Enter only one cause per line for (i PART I. DEATH WAS CAUSEO BY: IMMEDIATE CAUSE (a)	o), (b), ond (c)) Hepatic Fail	lure		ONSET AND OEATH
O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then bease remove carbon papers. Pages 1, and 2 shauld be filed with the State Dept. af Health priar ta burial, crematian, ar reinfiner and in any event, within 72 haurs after death		Conditions, if any, which gave (b) (b) (b) Crise to immediate cause (o), stating the underlying cause	Cirrhosis of			
TO HOSPITAL OR ATTENDING PHYSICIAN: The law rate Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the shauld be filed with the State Dept. af Health prior to	TION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO	Chronic Alco		GIVEN IN PART 1(σ)	19. WAS AUTOPSY PERFORMED? YES NO
SICIAN: spital ar ertificate ned far u	CERTIFIC	OR CONTRIBUTING CI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		Enter nature of injury in Port I or	•	
NG PHY y the ho er this e e detacl	MEDICAL	Haur o.m. While at wark	Nat While focto	ry, street, office bldg , etc.)		County) (State)
TTENDI cained b TOR: Afi hould b		21. I certify that (I) (this haspital) attends saw the deceased place an 1/10.	ed the deceased fram	12/30/, 1966 death accurred at 2:4	M, fram causes and an	67, that (I) (we) last the date stated abave. OATE SIGNED
LI OR A be ret billed wijled wij		22c PHYSICIAN'S	M.O	22d. ADORESS		/10/67
O HOSPITAL OR ATTENI Page 4 may be retained o FUNERAL DIRECTOR: A director, page 3 should shauld be filed with the	23	NAME (Type) L. Benedict, M. BURIAL (REMATION, 23b OATE THEREOF	23c NAME OF CEMETERY OR C	REMATORY 23d	State Hospita	(Caunty) (State)
r-1	2	REMOVAL (Specify) BURLA L FUNERAL DIRECTOR (BALTO. NATION	2Sq. REC'D BY REC	BALTO, MD GISTRAR 256. REGISTRAR'S	SIGNATURE SIGNATURE
VR A15 (4) , 4 / 20 M 1/66		Hatle W. llen - 2334	Jefferson &	OATE JAN 1	2 1967 your	0.

00701	CERTIFICATE OF DEATH	00138
1. PLACE OF DEATH a. COUNTY		here deceased lived, If institution: Residence before
Anne Erundel	maryland %. State Maryland	Anne Arundel
b. CITY OR TOWN (if outside corporete limits, write RURAL end give neerest town)		de corporete limits, write RURAL and give nearest to
St. Margarets	Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if no	of in hospital, give street eddress) d. STREET ADDRESS	e, IS
Bay Manor Nursing He	lome 207 Ridgly	Axes ON
3. NAME OF Fist	Middle Lest 4. 1	ATE Month Dey Ye
(Type or print) James	* 1	DEATH Tomorous 22 19
5. SEX 6. COLOR OR RACE 7 A	John Lorens MARRIED NEVER MARRIED 8. DATE OF B RTH	9. AGE (In years IF UNDER 1 YEAR IF UNDE
	TROUGH FEE	last birthday) Months Deys Hours
male white Wi	10b, KIND OF BUSINESS OR INDUSTRY II, BIRTHPLACE [County & S	late, or fore an country) 12. CITIZEN OF WHAT
done during most of working life, even if retired)		
blacksmith	Boundry German y	USA
James Lorens 15. WAS DECEASED EVER IN U.S. ARMED FORCES	unknown	A.44m
(Yes, no, or unknown) (If yes give we ror detes of service	(ce)	Address
no	219-16-1475 Mrs. Fillian Darde	
18. CAUSE OF DEATH Enter only one ceu: PART I. DEATH WAS CAUSED BY;	use pertitle for (a). (b) and (c)	INTERVAL B
IMMEDIATE CAUSE (a)	Oscalust Estulou Action	eul Herri
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18.71	Division of STATISTICAL RE	MARYLAND STATE DEPARTMENT OF HEALTH AL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
(VI)	25100	CERTIFICATE	OF DEATH	00139			
haurs after death	PRACE OF DEATH O. COUNTY ANNE ARUNDEL	MARYLAND 2	2. USUAL RESIDENCE (Where deceosed lived, if o. STATE MARYLAND	institution: Residence before odmission) COUNTY ANNE ARUNDEL			
	b. CITY OR TOWN (If outside corporate smits, write R. RAL and give nearest town). RURAL—CLEN BURNIE	2 DAYS	COLTY OR TOWN (IF outside corporate limits, with RURAL—BALTIMOF				
74	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospit NORTH ARUNDEL HOSPITAL	ol, give street oddress)	d. STREET ADDRESS 318 SNOW HILL ROAD	B IS RESIDENCE ON A FARM? YES NO X			
	3. NAME OF First DECEASED (Type or print) DECEASED	Middle	Lost 4. DATE	Month Doy Year ANUARY 25 1967			
-	S. SEX 6. COLOR OR RACE 7. MARRI MALE NEGRO WIDOW		DATE OF BIRTH ANNARY 1,1903 9 AGE (in your lost by the office of the o	eors IF JNDER YEAR IF UNDER 24 HRS. doy) Months Doys Hours Min			
	100 LSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR	o. KIND OF BUSINESS OR INDUSTRY cementary	II BIRTHPLACE (County & Stote, or foreign country NEW PORT NEWS, VIRGI	COUNTRY?			
	13 FATHER'S NAME SCORES SO	eve 1	4. MOTHER'S MAIDEN NAME	Cloudes			
	IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, prunknown) (If yes give wor or dotes of service)	16 SOCIAL SECURITY NO. 17 INFO	Canna Sore	Address			
	18 CAUSE OF DEATH (Enter only one couse per time PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Conditions if ony, which gove rise to immediate couse (o), stating the underlying couse DUE TO DUE TO	CARDING DEC	adial defantion -	INTERVAL BETWEEN ONSET AND DEATH			
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	Hour o.m. 19 of	Thile Not While foctory,	OF INJURY (Home, form, 20f (City or to , street, office bldg., etc.)				
med with the Stat	21. I certify that (I) (this haspital) att saw the deceased alive an 22a. SIGNATURE	tended the deceased fram 19 6 7, and that d	ATTENDING MED. STAFI	suses and an the date stated above. 22b. DATE SIGNED			
1	22c. PHYSICIAN'S NAME (Type) CARLOS E	ARRABAL	22d. ADDRESS 2705 MOUNTA/				
	230. BURIAL CREMATION, REMOVAL (Specify) 24. FUNERAL DIRECTOR.	23c NAME OF CEMETERY OR CRE THE ADDRESS	ruy com a, q.	y or Iown) (County) (Stote) Character Than SSD. REGISTRAR'S SIGNATURE)			
}	Rosalli, Eliclosen	112971. Cackeri	DATE JAN 3 0 1987	quartes jusque			



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00139 CERTIFICATE OF DEATH 00140 The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH o. COUNTY 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission b. COUNTY Maryland Anne Arundel Anne Arundel MARYLAND b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)
Annapolis c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate timits, write RURAL and give nearest town) 4 days Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Anne Arundel General Hospital YES T NO Barbud Lane and campletely fil remove carban p 3 NAME OF First DATE Manth Day Year DECEASED (Type or print) 1967 OF DEATH LUTTRELL Helen January 20 June IF UNDER 1 YEAR 9. AGF (In years IF UNDER 24 HRS. 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED 1 NEVER MARRIED last birthday)
50 yrs Months Days Haurs White WIDOWED April 20, 1916 Female DIVORCED 10a USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT physician c INDUSTRY Maryland 1700SEWIFE OME 14 MOTHER'S MAIDEN NAME HARRISON crematian, ar remo WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, go, of unknown) (If yes give wor or dates of service) LUTTRELL SR #2 INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per lim for (o), (b), and (c).) signed by the burral-transit p burrial, cremation PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE OF DUE TO Conditions, if any, which gove nse to immediate couse (a), DUE TO stoting the underlying couse the of Health priar ta 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES T NO certificate ď 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [2] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (City or town) (Store) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (County) 20c TIME OF INJURY Month, Doy, Year foctory, street, office bldg , etc.) Not While of work DIRECTOR: After ta Jan. 20., 1967, that (1) (War last 21. I certify that (I) (this laxpited) attended the deceased fram 19 19 67, and that death accurred at M, fram causes and an the date stated above. saw the deceased olive an 21-6.45 MED. DIRECTOR 22n SIGNATURE 22b DATE SIGNED STAFF PHYS director, page 3 shauld be filed v M.D. PHYSICIAN'S O FUNERAL NAME (Type) 23d. LOCATION (City or Town) NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION 23b DATE THEREOF (Stote) SHERWOOD SHERWOOD CEM 25o. REC'D BY REGISTRAR



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00140 CERTIFICATE OF DEATH 00141 The law requires that the death certificate be executed within 24 hours after death. edse remave carban papers. Pages 1 and 2 and 10 and on and campletely filled in by the funeral 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH p. COUNTY o. STATE b. COUNTY Anne Arundel Anne Arundel MARYLAND Maryland b CITY OR TOWN (If outside corporate limits, r. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Glen durnie Glen Burnie 18vrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS NO V (Glen Gardens) YES 🗔 #113 Kent Road #113 Kent Rd 3 NAME OF 4 DATE First Month Year DECEASED OF DEATH HECTOR (nmi) Mac Donald January 19 67 (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 8. DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthday) Months Hours Doys Feb. 19.1905 White WIDOWED Male DIVORCED 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter (10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? INDUSTRY Construction Sydney, Nova Scotia HSA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial-transit permit. Then p burial, crematian, ar remaval Margaret C. Mc Allister John J. Mac Conald IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. #2 (Yes, no, or unknown) [(If yes give wor or dates of service) Mrs. Nellie M. Mac Nomald(wife) Same 168-09-1365 DΩ none INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART DEATH WAS CAUSED BY ONSET AND DEATH signed by t IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO stating the underlying couse **ECTOR:** After this certificate has been 3 should be detached far use as the with the State Dept. of Health priar ta 19. WAS AUTOPSY PERFORMED? PART 11/OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of Item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year Hour o.m. factory, street, office bldg etc.) Not While ot work TO FUNERAL DIRECTOR: After director, page 3 should be d should be filed with the State ot work 21. I certify that (I) (this hospital) attended the deceased from Tan 31, 1953, to 1966, that (I) (we) lost saw the deceased alive an Sept 30, 1966, and that death occurred at 5:36 FM, from causes and an the date stated above. 22o. SIGNATURE 22b DATE SIGNED ATTENDING PHYS. M.D. DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 204 CRain 23d. LOCATION (City or Town) 230 BURIAL CREMATION. 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) Gate of Heaven Cemeter Wheaton, Maryland 7.1967 Buria 256. REGISTRAR S. SIGNATURE AECD BY REGISTRAS 67 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 RIchard V. Singleton Glen Burnie, Md.



1002 IAFAYETTE AVE 1002 IAFAYETTE AVE 1003 IMAME OF 1004 DETAIL JANUARY 1005 DETAIL JANUARY 1006 DETAIL JANUARY 1007 DECEMBER 1929 1006 DETAIL JANUARY 1007 DETAIL JANUARY 1006 DETAIL JANUARY 1007 DETAIL JANUARY 1006 DETAIL JANUARY 1007 DETAIL JANUAR	1	DIVISION OF	F STATISTICAL	RESEARCH AND RI				BALTIMORE 1	, MARYLA	ND
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15. WAS DECEASED FYEE IN U.S. ARRED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Name or unknown) (Ity PRS I I I I I I I I I I I I I I I I I I I	doi	SOLDIER Working	(Give kind of work g life, even if retired)			MOUNDSVIL	LE, W. VI			AT COU
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PERFOR YES N YES N YES N PERFOR YES N PERFOR YES N YES N PERFOR YES N YES N	7	Conditions, if any, we give rise to immediate (e), stating the under cause last.	DUE TO (b) cause rlying DUE TO (c)	SECONDARY TO	TRAUMA	ELAJED TO THE TERM	NINAL DISEASE CON	IDITION GIVEN IN P	4 H	OURS
21. I certify that XIX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CERTIFICATIO	20a ACCIDENT WAS OR CONTRIBUTING	UNDERLYING	206. DESCRIBE HOW INJURY	OCCURRED. (Enter nature of injury			PI	ERFORMI
ATTENDING MED. STAFF Y 21 JANUARY 1 22a. PHYSICIAN'S DIRECTOR PHYS. A 21 JANUARY 1 22a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Jan. 26, 1967 River View Cemetery, Moundsville, West Virginia 24 FUNERAL DIRECTOR'S SIGNATURE ATTENDING MED. STAFF Y 21 JANUARY 1 22b. MED. STAFF Y 21 JANUARY 1 22c. PHYSICIAN'S XIMBROUGH ARMY HOSPITAL FT GEO G. MEADE 22a. BURIAL, CREMATION, 23b. DATE THEREOF PHYS. A 21 JANUARY 1 22b. RECORD MED. STAFF Y 21 JANUARY 1 22c. PHYSICIAN'S XIMBROUGH ARMY HOSPITAL FT GEO G. MEADE 22a. BURIAL, CREMATION, 23b. DATE THEREOF PHYS. A 21 JANUARY 1 22b. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	MEDICAL	Hour e.m.	19	While Not While at work at work	fectory,	, street, office bldg., et	tc.]			(Sla
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		REMOVAL (Specify)	Jan. 26, 1	OF 23c. NAME OF C		tery,	Mounds	on (City, town or co	uniy) st Virgi	(State)
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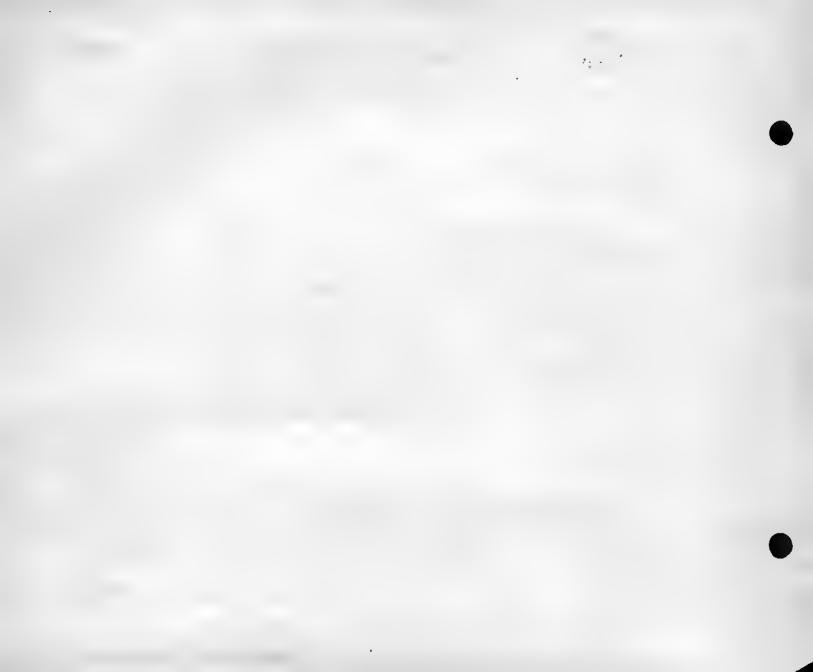
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 00143 HEALTH DERT 2. USUAL RESIDENCE (Where deceased lived of institution Residence before admission) PLACE OF DEATH b COUNTY o COLNTY o STATE MARYLAND b CITY OR TOWN (If outside corporate imits. c LENGTH OF STAY N 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RuRAL ont give neorest town) BURNIE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS haurs 4100 Belo NORTH. ARUNDEL- HOSBILDL YES 🔲 NO 🖼 3. NAME OF Middle Lost DATE Doy Year DECEASED Z MANN 19 67 2/ (Type or print) DEATH 5 SEX 8. DATE OF BIRTH 9. AGE (In years IF LADER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE NEVER MARRIED lost birthdoy) Months Days Hours 9-14-56 WIDOWED DIVORCED 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or fore an country) COUNTRY? during most of working life, even if retired) INDUSTRY USA Housewife Md 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME penci Daniel Pfeltz Anna Rhoades IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no. arthknown) (If yes give wor or dotes of service) Femily Same or removol, 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY Kronel mysicald IMMEDIATE CAUSE (o) 15 hours cremotion, DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stoting the underlying couse burnal, 1 19 WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION ON GIVEN IN PART 1(0) PERFORMED? NO D agent, prior ta 200 EXTERNAL CAUSE WAS 20h DESCRIRE HOW INJURY OCCURRED Enter nature of more in Port 1 or Port II of Item 18.) PRIMARY I or CONTRIBUTING I CALSE OF DEATH 20e PLACE OF INJURY (Home form, (City or town) (County) (Stote) 20c TIME OF INJURY Month Dov. Year factory, street office blog., etc.) Hour om Not Whe MA 21. I certify that I taak charge of the remains-described above, held an Autapsy Inspection I Inquiry I and in my apinion Netural causes 1. Accident 1. Suicide . Hamicide 🗍 Undetermined manner death resulted from-CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY DEPLTY MEDICAL EXAMINER 5 TO FUN. **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) the 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 230 BUR AL, CREMAT ON, Bu REMOVAL (Speary) 1/25/67 Cedar Hill AA Co Md 25b. REGISTRAR S SIGNATURE ADDRESS 2So. REC'D BY REGISTRAR 24 FLNERAL DIRECTOR VR A15ME (5) McCully F H 237 Patapsco Ave 21 225 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00143 CERTIFICATE OF DEATH ond 2 Beathar death. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 1. PLACE OF DEATH and completely filled in by the funeral remove carbon papers Pages 1 and b. COUNTY p. COUNTY o. STATE Anne Arundel Marvland Wikert Anne Arundel MARYLAND law requires that the death certificate be executed within 24 hours after c LENGTH DE STAY IN 15 c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) b CITY DR TOWN (f outside carporate limits, write RURAL and give nearest town)
Glen Burnie Glen Burnie IS RESIDENCE ON A FARM? d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #10 "D" Street S/W ND X North Arundel Hospital Middle 4 DATE Year 3 NAME OF Lost First DECEASED JR. DEATH ALBERT MARINER GEDRGE 19 6 (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years DATE OF BIRTH 6 CDIOR OR RACE S SEX 7 MARRIED . NEVER MARRIED Months lost birthdoy) Dovs Hours WIDOWED DIVORCED June 21,1911 White Male 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT Ob. KIND OF BUSINESS OR 100, USUAL OCCUPATION (Give kind of work done COUNTRY? INDUSTRY during most of working ife, even if retired) Service Baltimore, Md. Supervisor Civil 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Martha Wolf Albert G. Mariner 17 INFORMANT Address 16. SOCIAL SECURITY NO WAS DECEASED EVER IN U.S. ARMED FORCES? burial-transit permit. (Yes, no, or unknown) (If yes 215/03/7179 Mrs. Doris R. Mariner Same as ÎNTERVAL BETWEEN CAUSE OF DEATH (Enter on y one cause per line for (o), (b), and (c)) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) physicion. DUF TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse os the this certificate has been WAS AUTOPS'S PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION NO X 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH director, page 3 should be detached should be filed with the State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) (County) (Stote) 20e. PLACE OF INJURY (Home, form, (City or town) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour om. Not While ot work O FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased from 19 saw the deceased alive an 1967, and that death accurred at 1967, that (1) (vie) last Poge 4 may be retained ZA - M, fram causes and an the date stated above 22b. DATE SIGNED 22o SIGNATUI STAFF PHYS ATTENDING DIRECTOR M.D. ADDRESS 22c. PHYSICIAN 5 5 Central Ave. Glen Burnie, Md. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 230 BURIAL, CREMATION 23b DATE THEREOF Pikesville Jan.19,1967 Druid Ridge Cemetery Md. 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 GLEN BURNIE. MD. R.V. SINGLETON DATE! A N

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00144 CERTIFICATE OF DEATH 00146 The low requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY o. STATE b. COUNTY Anne Arundel Maryland impletely filled in by the fur ye corbon papers. Pages 1 event, within 72 hours offer MARYLAND Anna Arundel CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Annepolis Annapolis IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) d. STREET ADDRESS Anne Arundel General Hospital 4 Severn Drive 3. NAME OF 4 DATE First Middle Last Month Year DECEASED 19 67 DEATH January Martha Ann MAY (Type or print) B. DATE OF BIRTH IF UNDER 24 HRS S. SEX AGE (In veors IF UNDER 1 YEAR 6 COLOR OR RACE 7. MARRIED NEVER MARRIED lost hirthdoy) Months Days Hours White June 21, 1925 Female WIDOWED X DIVORCED 10c USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 11. BIRJHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) **COUNTRY?** attending physicians DUPER UISBR WEST VIRGINIA U. S. 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME buriol, cremation, or removal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, ar unknown) (If yes give wor or dates of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per lines for (a), (b), and (c).) buriol-tronsit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if ony, which gave rise to immediate couse (a), DUE TO stoting the underlying couse director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to last. WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) this certificate has CERTIFICATION YES -NO PHYSICIAN: 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED Hour 'a.m. factory, street, affice bldg, etc.) Not While nt work of work 196767 to. 1-5-1907, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased from 7-21 saw the deceased alive an_ and that death accurred at from causes and an the date stated above. 22a SIGNATURE 22b. DATE SIGNED PHYS M.D PHYS DIRECTOR ADDRESS 22c. PHYSICIAN S O HOSPITAL FUNERAL NAME (Type) 121 Cathedtal St., Annapolis, Md. Barber C. Palmer, M.D. 23b DATE THEREO 23d LOCATION (City of Town) (State) BURIAL CREMATION? (County) REMOVAL (Specify) MIG 0 256. REG STRAR'S SIGNATURE 250. REC'D BY REGISTRAR VR A15 (4) 25M 1/67



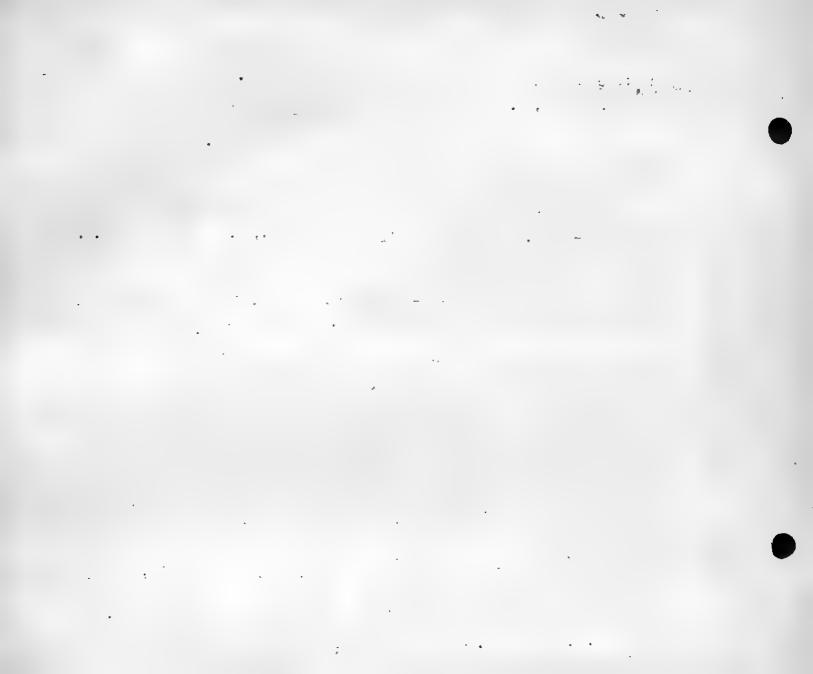
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9	A STATE OF THE STA	1	00145 CERTIFICATE OF DEATH	00147
	uneral I and 2 r death:	-		stitution. Residence befare odmissian) COUNTY ,
	reate be executed within 24 haurs after deal		b. CITY DR TOWN (if autside corporate limits, write RURAL and give nearest town) c LENGTH DF STAY IN 1b c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	e RURAL and give nearest town)
•	l 24 har led in the papers.	1,	Crownsville 4 years 316 Zeppelin Ave d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Crownsville State Hospital Baltimore	e IS RESIDENCE DN A FARM? YES ND T
	within etely fill arbon p		3 NAME OF First Middle Lost 4. DATE OF OF OF DECEASED (Type or prints #2),760 Arcicle McClain DEATH	Month Doy Year
	xecuted d campl mave c		S. SEX 6 COLDR OR RACE 7 MARRIED NEVER MARRIED 8. DATE DF BIRTH 9. AGE (In yet lost birthdo	yrs. Months Doys Hours Min.
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	death ottendin ermit. m, ar re		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates af service) no 16. SDCIAL SECURITY NO 17. INFORMANT Hospital Records	INTERVAL BETWEEN
	equires that the death certifuthy signed by the attending of burial-transit permit. That burial, cremation, ar removal		18 CAUSE OF DEATH (Enter only one couse per line for (0), (b) ond (c).) PART I. DEATH WAS CAUSED BY: MMMEDIATE CAUSE (a)	ONSET AND DEATH
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	e law retending is been as the prior ta		lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 10	(a) 19. WAS AUTOPSY PERFORMED?
	AN: The old or of core hor or of for use for use Health	2	200 ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port L or Port II of item 1)	YES NO
	PHYSICI haspit iis certif tached Dept. of		(I CHICK, IVIII) III. (I CALL CALLED COLUMN	vn) (Caunty) (Stote)
	d by the Affer It be de le State le		21. I certify that (I) (this haspital) attended, the deceased fram 1/28/ 1963, ta 1/3	23/, 19_6'(that (I) (we) last
	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death be retained by the haspital ar attending physician. DIRECTOR: After this certificate has been signed by the attending of certificate and completely filled in by the funeral as 3 shauld be detached for use as the burial-transit permit. This phase remove carbon papers. Pages 1 and 2 ed with the State Dept. of Health prior to burial, cremation, ar removal, and in any event, within 72 haurs after beath.		saw the deceased alive on 1907, and that death accurred at 1:30 M, fram cat 22d skignarure M.D. ATTENDING MED. PHYS DIRECTOR DIRECTOR PHYS	22b. DATE SIGNED 1/23/67
	may be RAL DIR page be filed	/	22d ADDRESS NAME (Type) Hildagard Heard Reissman, M.D. Crownsville STa	
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 shauld be detached for use as the burial-transhould be filed with the State Dept. of Health prior ta burial, cre-		230 BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City REMOVAL (Specify))	LLE -N.C.
	VR A15 (4) 20 M 1/66	<-	24. FUNERAL DIRECTOR March Possing & 38 v C. mar St DAVEAN 24 1967	galantes Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00146 CERTIFICATE OF DEATH 00144 requires that the death certificate be executed within 24 haurs after death. signed by the attending physician and completely filled in by the funeral burial-transit permit. Then please remove carban papers. Pages 1 and 3 burial, cremation, ar removal, and in any event, within 72 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 15 (If outside corparate limits, write RURAL and give nearest town) write RURAL prid give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO-NAME OF First Middle 4. DATE Last Month Day Year DECEASED OF 15 C551R -(Type or print) DEATH 19 IF UNDER 1 YEAR S SEX 6 COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE (In years IF UNDER 24 HRS NEVER MARRIED lost birthdoy) Months Davs Haurs WIDOWED DIVORCED 1Do. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME/ GC WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANI 16 SOCIAL SECURITY NO. Address (Yes, na, or unknown) (If yes give war at dates of service CAUSE OF DEATH (Enter only one couse per line INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse the has been last. PHYSICIAN: The law 20 PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) WAS AUTOPSY PERFORMED? be detached for use State Dept, of Health YES [NO O FUNERAL DIRECTOR: After this certificate 2Do ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 2Dc TIME OF INJURY Manth, Doy, Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour to m. foctory, street, office bldg., etc.) Not While ATTENDING at wark at work 21 I certify that (1) (this haspital) attended the deceased from 19____, that (I) (we) last saw the deceased alive an and that death accurred at M, from causes and an the date stated above 22a. SIGNATURE 22b. DATE SIGNED director, page 3 should be filed v M.D DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) (NINGPOLIS 24. FÜNERAL DIRECTOR 250 REC'D BY REGISTRAR

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LI PLACE OF DEATH 2. USUAL RESIDENCE (Where docased lived, if institution? Residence before redusision? Anne Arundel 3. STATE Md. 4. CITY OR TOWN (if outside corporate limits,		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR	OVIAND
a. STATE Md. b. COUNTY Anne Arundel b. CITY OR flown of outside corporate limits. C. LENGTH OF STAY IN 10 C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR FOWN (if outside corporate limits, write RURAL and give	1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital	-	a. COUNTY Anne Amindel Maryland b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) a. STATE Md. b. COUNTY Anne C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Arundel
DECEASED Type or print) To see the company of the country of the		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. Singer Address d. Singer Address d. Singer Address 104 Ridge Rd.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY Balto., Md. 10b. KIND OF BUSINESS OR INDUSTRY 10b. KIND OF BUSINESS OR INDUSTRY Balto., Md. 10b. KIND OF BUSINESS OR INDUSTRY 10b. KIND OF BUSINESS OR INDUS		DECEASED (Type or print) Charles Fimory Merryman DEATH January SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH WINDOWED DIVIDENT DAY Months Day	19 67 AR F UNDER 24 HRS.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None 215-03-5953 Mrs. Pansy V. Merryman same address 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).1 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II or Par	ı	OB. USUAL OCCUPATION (Cive kind of work done uring most of working life, even if retired) Retired - Supt. OB. USUAL OCCUPATION (Cive kind of work done lind) INDUSTRY American Oil 11. BIRTHPLACE (County & State, of eign country) Balto., Md. U.S.	EN OF WHAT TRY?
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II of Item 18.) 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20f. (City or town) (State) 4	100	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Yes, no, or unknown) (If yes give war or dates of service) None 215-03-5953 Mrs. Pansy V. Merryman same addre	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part 11 of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part 11 of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) Factory, street, office bidg., etc.) ATTENDING MED. STAFF ATTENDING MED. STAFF ATTENDING MED. STAFF		Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (c) Conditions, If any, which part is any content of the cause (a), stating the underlying cause last.	NTERVAL BETWEEN ONSET AND DEATH
21. I certify that (I) (this hospital) attended the deceased from		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	MEDICAL	21. I certify that (I) (this hospital) attended the deceased from	that (I) (we) last date stated above.
	2	24. FUNERAL DIRECTOR ADDRESS - 1252. REC'D BY REGISTRAR 250. REGISTRAR'S SI Wm. J. Tichner & Sono with 2 rec. Date JAN 17 1967 years	



5	1 (2)	MARYLAND STATE D Division of STATISTICAL RESEARCH AND RECORDS, 30	EPARTMENT OF HEALTH DI W. PRESTON STREET, BALTIMORE, MARYLAND	21201
	(IVI)	00148 CERTIFICAT	E OF DEATH	00149
	physician and completely filled in by the funeral physician and completely filled in by the funeral physician conditions are across carbon papers. Pages 1 and exalgand in any event, within 72 hours after death	PLACE OF DEATH O COUNTY AFIRM ATLIFICEL MARYLAND B CITY OR TOWN (H autside carparate limits, c. LENGTH OF STAY IN 15	c CITY OR TOWN (If autside carparate limits, write RURAL and	Arundel
	taurs by tl s. Pog hours	b (ITY OR TOWN (If autside carparate limits, write RURA, and give nearest fown) LTOWINSVIILE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)	Annapolis d. STREET ADDRESS	e IS RESIDENCE
	n 24 } Illed ir poper iin 72	Crownsville State Hospital	908 Boucher Avenue	e IS RESIDENCE ON A FARM? YES NO X
	ed withi	3 NAME OF OCCEASED (Type or pnnt) 3-#27735 James L.	Lost	Doy Year 30 19 6.7 NOER 1 YEAR IF UNDER 24 HRS
	execute d comp pmove any eve	Male White WIDOWED □ DIVORCEO □	Dec. 16, 1908 (ast birthday) Mant	
	te be tion on gose re	100 USUAL OCCUPATION (Gree kind of work done during most of working life, even if retired) Blacksmith	Maryland	COUNTRY?
	physic	James B. Messick	14 MOTHER'S MAIDEN NAME Mary Ellen Thomas	3
	deoth tending mit.	15 WAS DECEASED EVER IN L. S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war or dates of service) 16. SOCIAL SECURITY NO 212-12-96.72	Hospital Records	
	OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 haurs after deoth be retained by the hospital or ottending physician. SIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral e 3 should be detoched for use as the burial-transit permit. The flesse remove carbon papers. Pages I and 2 ed with the State Dept. of Health prior to burial, cremotion, or removal and in any event, within 72 hours after death	IB. CAUSE OF OEATH (Enter only one couse per kine for (a), (b), and (c).) PART I. OEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Hemorrhagic DUE TO Conditions, if ony, which gove rise to immediate couse (o), stating the underlying couse lost. (c) Carcinoma of Right	Tracheo-Bronchitis pneumonia, Bilateral	INTERVAL BETWEEN ONSET AND OEATH
	AN: The low rail or ottending it of the bas been for use as the Health prior to	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19 WAS AUTOPSY PERFORMED? YES X NO
	Page 4 may be retained by the hospital or ottending to FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detoched for use as the should be filed with the State Dept. of Health prior to	C.B.S. due to Chronic Alcoholism; Cirr 20g ACCIDENT WAS UNDERLYING I 20b DESCRIBE HOW INJURY OCCURRED (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Ooy, Yeor Hour a m. 20d INJURY OCCURRED While Not While I Not While I Represented to the process of the pro	D. (Enter noture of injury in Port I or Part II of item 18.)	
	IG PHYSIC the hospit in this certificated detoched ite Dept. of	20c. TIME OF INJURY Month, Ooy, Yeor 20d INJURY OCCURRED 4 While 1 Not While 1 work 1	LACE OF INJURY (Home, form, octary, street, affice bldg , etc.) 20f. (City or town)	(County) (State)
	ATTENDIN etained by CTOR: After should be rith the Sta	21. I certify that (I) (this haspital) attended the deceased framsaw the deceased alignment 1/30 y 87, and the	nat death accurred a $\frac{2:30}{}$ M, fram causes and (
	D HOSPITAL OR ATTEND Page 4 may be retained FUNERAL DIRECTOR: A director, page 3 should should be filed with the !	220 SIGNATURE NEWWORK	M.O. ATTENDING MED STAFF PHYS. 22	26. DATE SIGNED 1/30/67
	O HOSPITAL Page 4 may O FUNERAL I director, pag should be fil	22c PHYSICIAN'S NAME(Type) L. Benedict, M. D.	Crownsville State Hospi	
	\wedge B	230 BURIAL, CREMATION, REMOVAL (Specify) Feb. 2, 1967 Edwards Charles Feb.	Riva 250 REC'D BY REGISTRAR 25b. REGISTRA	(County) (Stote) A.A. Md. AR'S SIGNATURE
	VR A15 (4)	Hopping Funeral Home Annapolis Md.	DATE FEB 3 1967 (C)	willy Judon



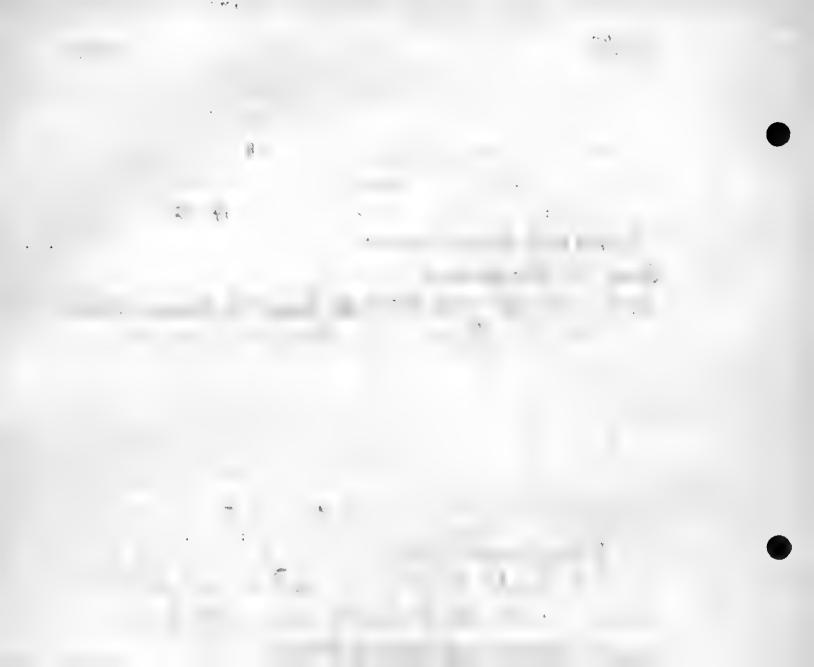
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY ve carbon papers. Pages 1 event, within 72 hours after MARYLAND TOWN (If outside corporate limbs, wifte RURAL and give nearest town OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 1b c. CITY OF à write RURAL and give reavest town 2, e. IS RESIDENCE NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give exceet address) filled ADDR ESS ON A FARM NO YES completely Month Day Year, NAME OF Middle OF DEATH DECEASED 19 (Type or print) AGE (In years | FUNDER 1 YEAR | last birthday) | Months | Days IF UNDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH 5. SEX NEVÉR MARRIED 7. MARRIED [ЯШВ WIDOWED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign county) C 10a. USUAL OOCUPATION (Give kind of work done) working life, even if retired) þe certificate MOTHER'S MAIDEN NAM Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no. or unknown) | CHY ves give war or dates of service) 16. SOCIAL SECURITY NO. -INFORMAN L DIRECTOR: After this certificate has been signed by the atten page 3 should be detached for use as the burial-transit permit. Bled with the State Dept. of Health prior to burial, cremation, or death INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH PART I, DEATH WAS CAUSED BY: 2-41602 the hospital or attending physician. IMMEDIATE CAUSE (a) Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. CERTIFICATION NO D YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) (State) MEDICAL (County) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While be retained by at work at work 19.4 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at /C AM, from the causes and on the date stated above. saw the deceased alive on. 22b. DATE SIGNED 22a. SIGNATURE MED.
DIRECTOR ATTENDING PHYS. M.D. PHYS. 4 шау 22d. ADDRESS O FUNERAL PHYSICIAN'S director, p NAME (Type) LOPATION (City, town or county) NAME OF CEMETERY OR 23d. BURIAL, CREMATION, DATE THEREOF 23c. REMOVAL (Specify) REC'D'BY REGISTRAR ADDRESS VR A15 (4) 15M 4-64



00150	CERTIFICATE	OF DEATH			0013	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDE				nce before a dmissio
Anne Arundel	MARYLAND	"Marylan	d	Anne	e Arundel	1
b. CITY OR TOWN (if outside corporate limits, write RURAL and give neerest town)	c. LENGTH OF STAY IN 15	c, CITY OR TOWN	N (If outside corpo	orata İlmilis, write	RURAL and give	nearest town)
Ft G.G. Meade. Maryland	l DOA	Glen Bu				,
d. NAME OF HOSPITAL OR INSTITUTION (if not in	hospital, give street eddress)	d, STREET ADDRES				e, IS RESIDENC
Kimbrough Army Hospital		1	or Drive			YES NO X
NAME OF First DECEASED	Middle	1.est	4. DATE OF	Month	n Day	Yeer
(Type or print) Mary 6. COLOR OR RACEL 2. MAR	Gladys	Miller	DEATH	Janu		1967
7. MAK		DATE OF BIRTH		AGE (In years last birthday)	Months Deys	IF UNDER 24 HRS.
		25 March 19 0		6D yrs.		
done during most of working life, even if retired)	. KIND OF BUSINESS OR INDUSTR			loreigh country)		OF WHAT COUNTR'
None	None	Fort Dodge			US	5A
Edward Lilly		Nettie Boy				
	IA SOCIAL SECURITY NO 1-17 1	_				
(Yes, no, or unkown) (Ifyesgivewar or detes of service)	128-09-1746 17. 1	hn B Va Ca	(CTT)		or Drive	
18. CAUSE OF DEATH [Enter only one cause pr	*Gridanomin* Jo	hn T. Mc Co	DA (DITT)	Glen Bu	rnie, Ma	מתפ דינים
	at line for (e) (b) and (c)]		7			
PART I. DEATH WAS CAUSED BY:					[IN1	TERVAL BETWEEN NSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)C	ar line for (e), (b), and (c).				[IN1	TERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) OUE TO			ALL COMMENTS AND THE STREET AND THE		[IN1	TERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which geve rise to immediate cause					[IN1	TERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) OUE TO Conditions, if any, which geve rise to immediate cause [a), stating the underlying DUE TO			and American Adv. Adv. Section 2		[IN1	TERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) OUE TO Conditions, if any, which geve rise to immediate cause (a), stating the underlying cause lest. (c)	ancer	T RELATED TO THE TER/	MINAL DISEASE C		INI	TERVAL BETWEEN NSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) OUE TO Conditions, if any, which geve rise to immediate cause (a), stating the underlying cause lest. (c)	ancer	T RELATED TO THE TERA	MINAL DISEASE C		EN IN PART 1(e) 1	TERVAL BETWEEN NSET AND DEATH 19. WAS AUTOPSY PERFORMED?
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PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) Conditions, if any, which geve rise to immediate cause [a), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED 200, PLA	D. (Enter nature of injury	y in Part or Pert	CONDITION GIVI	EN IN PART 1(e) 1	TERVAL BETWEEN NSET AND DEATH 19. WAS AUTOPSY PERFORMED?
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED J. INJURY OCCURRED 20%, PLAN	D. (Enter nature of injury	y in Part or Pert	CONDITION GIVI	EN IN PART 1(e)	TERVAL BETWEEN NSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES NO
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED 200, PLA- hile Not While facts work at work	D. (Enter nature of injury CE OF INJURY (Home, fi ory, street, office bldg., e	y in Part or Part arm, 20f. (City stc.)	CONDITION GIVI	EN IN PART 1(e) 1 (County)	IP. WAS AUTOPSY PERFORMED? YES NO (State)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) Conditions, if any, which geverise to immediate cause [a), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 W. 21. I certify that IKI because IV.	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED hille Not While fects work st work	D. (Enter nature of injury CE OF INJURY (Home, forcy, street, office bldg., e.	erm, 20f. (City	ONDITION GIVI	EN IN PART I(e) 1 (County)	IS. WAS AUTOPSY PERFORMED? YES NO (State)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED hille Not While fects work st work	D. (Enter nature of injury CE OF INJURY (Home, for pry, street, office bldg., etc.) Was DOA at., death occurred at.	erm. 20f. (City stc.)	or town) 1220, 1 the causes a	EN IN PART I(e) 1 (County)	19. WAS AUTOPSY PREFORMED? (State)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) Conditions, if any, which geve rise to immediate cause (a), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS C 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 et w	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED hille Not While fects work st work	D. (Enter nature of injury CE OF INJURY (Home, fi ory, street, office bldg., e Was DOA .at., death occurred at. ATTENDING	erm, 20f. (City	ONDITION GIVI	(County) Jan 197., 1	19. WAS AUTOPSY PREFORMED? (State)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) Conditions, if any, which geve rise to immediate cause (a), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19 et y 21. I certify that INCOMPANAMEN 22c. SIGNATURE 22c. PHYSICIAN'S	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED work 200, PLA- fector fector fector for work American	D. (Enter nature of injury CE OF INJURY (Home, forcy, street, office bldg., e Was .DOA .at., death occurred at] D. ATTENDING PHYS	r in Part I or P	or town) 1220 1 the causes a	(County) Jan 167 t	19. WAS AUTOPSY PREFORMED? YES NO (State) (State) 19. WAS AUTOPSY PREFORMED? YES DO (State)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) Conditions, if any, which geve rise to immediate couse [a), stating the underlying couse lest. PART II. OTHER SIGNIFICANT CONDITIONS CO 20a ACCIDENT WAS UNDERLYING 20b. OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dey, Yeer 20 Hoer a.m. p.m. 19 21. I certify that INCOMPACED IN STANDARD CONTRIBUTIONS CO 22e. SIGNATURE	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED work 200, PLA- fector fector fector for work American	D. (Enter nature of injury CE OF INJURY (Home, forcy, street, office bldg., e Was .DOA .at., death occurred at] D. ATTENDING PHYS	r in Part I or P	or town) 1220 1 the causes a	(County) Jan 167 t	19. WAS AUTOPSY PREFORMED? (State)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) Conditions, if any, which geve rise to immediate cause [a), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year P.m. 19 21. I certify that INCOMPRESSION 22c. Physician's NAME (Typer Cherick J. Bat 23c. BURIAL, CREMATION, 23b. DATE THEREOF	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED work 200, PLA- fector fector fector for work American	D. (Enter nature of injury CE OF INJURY (Home, fi ory, street, office bldg., e Was DOA at., death occurred at. ATTENDING PHYS. 22d. ADDRESS Kimbrough	erm. 201. (City stc.) 20PMrom MED. DIRECTOR Army Ho	or town) 1220 1 the causes a	(County) Jan 167 t and on the da I Janua Ft G.G.	19. WAS AUTOPSY PREFORMED? YES NO (State) (State) 19. WAS AUTOPSY PREFORMED? YES DO (State)
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (e)	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED bille Not While focts work at work had becaused 10556. COCOCOSOCOCOS HAT HAT Chl, CPT, MC 23c. NAME OF CEMETERY C	D. (Enter nature of injury CE OF INJURY (Home, fory, street, office bldg., e Was DOA at., death occurred at. ATTENDING PHYS. 22d. ADDRESS Kimbrough DR CREMATORY	or Part I or Par	or town) 1220, 1 the causes a STAFF PHYS. 2	(County) Jan 167., to and on the da I Janua Ft G.G.	19. WAS AUTOPSY PERFORMED? YES NO (State) 19. WAS AUTOPSY PERFORMED? YES AUTOPSY PERFORMED? YES AUTOPSY PERFORMED? YES AUTOPSY PERFORMED? (State)
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (e) Conditions, if any, which gover rise to immediate cause (a), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dey, Yeer 20c. Hour a.m., 19 et w. 21. I certify that IX DES REPOSED CONTRIBUTE 22c. PHYSICIAN'S NAME (Type) PREMOVAL (Specify) 13c. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)	ONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OCCURRED d. INJURY OCCURRED bille Not While facts work st work the deceased MASS COCOCOSOCOMA that Backle M. chl, CPT, MC	D. (Enter nature of injury CE OF INJURY (Home, fory, street, office bldg., e Was DOA at., death occurred at. ATTENDING PHYS. 22d. ADDRESS Kimbrough DR CREMATORY Memorial 25e. F	orm, 201. (City stc.) Me XXX. 220PMrom MED DIRECTOR 1 Army Ho 23d. LOCA Ph G1e	or town) 1220, 1 the causes a STAFF PHYS. 2	(County) Jan 167., to and on the da I Janua Ft G.G.	ISERVAL BETWEEN NSET AND DEATH IP. WAS AUTOPSY PERFORMED? YES NO (State) (State) (State) Meade, Mo (State)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00151 00152 deoth. funeral 1 ang PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission.) o. COUNTY o. STATE **6 COUNTY** Maryland Lidn and completely filled in by the fur lease remove corbon papers. Pages I and in any event, within 72 hours after Anne Arundel Anne Arundel be executed within 24 hours after MARYLAND b CITY OR TOWN (If outside carparate limits, C LENGTH OF STAY IN 1h c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give negrest town) Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? filled i 828 Janice Drive Anne Arundel General Hospital NO TY YES 3. NAME OF Middle 4. DATE Year Dav DECEASED MORELAND DEATH January (Type or print) 19 67 James SFX AGE (In years IF LINDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 8 DATE OF BIRTH 7 MARRIED **NEVER MARRIED** (ast birthdoy) Manths Doys Haurs DIVORCED 7.1 November WIDOWED Male 100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR BIRTHP_ACE/(County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? Maryland U. S. The low requires that the death certiffeate 13. FATHER'S NAME MOTHER'S MAIDEN NAME buriot, cremation, or remayol, ottending priva 16 SOCIAL SECURITY NO INFORMANT INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause portine for (o), (b), and (c).) signed by the buriol-tronsit PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) by the hospital or attending physician. Conditions, if only, which gove rise to immediate cause (a), DUE TO stating the underlying cause os the lost. 19. WAS AUTOPSY PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Heolth p NO -YES certificote 6 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port 1) of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 204 INJURY OCCURRED 2De. PLACE OF INJURY (Home, form. (City or fown) (State) 2Dc, TIME OF INJURY Month, Doy, Year (County) Hour to m. factory, street, office bldg., etc.) While Not While ATTENDING DIRECTOR: After ot work 21. I certify that (1) (this haspital) attended the deceased from Poge 4 may be retained and that death accurred at fram causes and an the date stated above. saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D PHYS PHYS , page 3 PHYSICIAN S 22d. O FUNERAL NAME (Type) director, shauld by THEREO BURIAL, CREMATION rry or Town) (Stote (County) HILLCREST APOLIS FUNERAL DIRECTOR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00152 CERTIFICATE OF DEATH 00154 The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o STATE b. COUNTY MARYLAND n ony event, within 72 hours after b CLTY OR TOWN (If outside corografe c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) filled in I popers. INSTITUTION (If not in hospital, give street address) STREET ADDRESS IS RESIDENCE ON A FARM? YES X NO [NAME OF Middle DATE Month remove carbon First Day Year completely DECEASED (Type or pnnt) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years 7 MARRIED **NEVER MARRIED** birthdoy) Months Doys Hours WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR ty & State, or foreign country) 12 CITIZEN OF WHAT, during most of working life, even if retired) **COUNTRY?** 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremotion, or removi NWIE IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (Yes, no. or unknown) (If yes give wor or dates of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying couse os the oge 3 should be detached far use as the filed with the State Dept. of Health prior to WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) YES NO certificate 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg, etc.) Not While at work **DIRECTOR:** After 21. I certify that (I) (this hospital) attended the deceased from 19___, that (I) (we) last 19 ta. and that death accurred at 2 AM M. from causes and an the date stated above saw the deceased olive and 220 SIGNATURE 22b. DATE SEGNED M.D PHYS DIRECTOR director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S O HOSPITAL O FUNERAL NAME (Type) DERN BUR AL CREMATION 23b DATE THEREOI NAME OF CEMETERY OR CREMAJORY LOCATION (City or Town) (Couphy) (Stote) 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR S SIGNATURE DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00155 00153 death. puo by the ortenang physicion and campletely filled in by the funeral transit person. Pages I and cremotion, a cereous after deat cremotion, a cemoval, and in any event, within 72 hours after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY . 2 Anne Arundel Maryland MARYLAND requires that the death certificate be executed within 24 haurs after b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate hm.ts, write RURAL and give nearest town) 4 months d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mavo d STREET ADDRESS IS RESIDENCE ON A FARM? Crownsville State Hospital Box 327 - Beverly Beach NO I YES 3. NAME OF Middle 4. DATE First Last Yeor DECEASED OF DEATH 19 67 Murphy H. #33182 Joseph Type or prent) 8. DATE OF BIRTH S SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 12/5/94 White WIDOWED Male DIVORCED 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11 BIRTHPLACE (County & State, or foreign country) 106 KIND OF BUSINESS OR 12 CITIZEN OF WHAT INDUSTRY COUNTRY? HSA Maryland Fed. Gov. (ret. 14. MOTHER'S MAIDEN NAME Unknown John Murphy IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dates of service) Hospital Records Unknown 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the buriol-tronsit p buriol, cremotia ONSET AND DEATH PART I DEATH WAS CAUSED BY. Respiratory Insufficiency IMMEDIATE CAUSE (o) DUE TO Bronchectasis Emphysema: Conditions, if ony, which gove rise to immediate cause (a). DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been os the Bronchopneumonia PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY PERFORMED? CERTIFICATION CBS with Cerebral Arteriosclerosis YES 🗍 NO K 20g ACCIDENT WAS UNDERLYING IT 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) TIME OF INJURY Month, Day, Year Not While factory, street, office bldg., etc.) 21. I certify that (I) (this hospital) attended the deceased from_ 9/2/ 1966 ... ta. 1/3/ 1967, that (I) (we) last 1/3/_ 1967 and that death accurred at 9: P. M. fram causes and an the date stated above. saw the deceased aliveran_ .22b. DATE SIGNED 4 22o. SIGNATURE MED DIRECTOR **ATTENDING** K M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S Benedict, M.D. Crownsville State Hospitab, MD. NAME (Type) 230 BURIAL, CREMATION, DEMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 25 REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE Marley Judes



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00156 10154 requires that the death certificate be executed within 24 hours after death funeral 1 and and 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) 1. PLACE OF DEATH dea o. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If autside corporate limits. c LENGTH OF STAY IN 1b c. CITY OR TOWN (If gutside carparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) Glen Burwer Glen Burnie d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Branch Rd. Glen Burnie. Arundel Hospital 3. NAME OF First Middle Lost 4. DATE Month Doy Year DECEASED Eda. Music Janury (Type or print) Ruth 19 DEATH IF UNDER I YEAR IF UNDER 24 HRS. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BIRTH AGE (In years remove lost birthday) Months Doys 8-04-06 Hours DIVORCED WIDOWED 100 LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPEACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Tenn (Cumberland Co.) School Teacher A.A. Co. Schools USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William Music Mary Margaret 16. SOCIAL SECURITY NO 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Xes, no, or unknown) (If yes give war or dates of service) 늄 JN0 None Same as Unknown Mrs. Thelma M. Lowe (sister) INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) signed by the barrial-transit p PART 1 DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o' DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse as the has been iost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES | NO T O FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS UNDERLYING 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (Stote) 20c TIME OF INJURY Month, Day, Year (County) Hour p.m. factory, street, office bldg., etc.) Not While ot work 2) I certify that (1) (this haspital) attended the deceased from VAN & 7, 1967, to VAN & 2, 1967 that (1) (we) last saw the deceased alive on VAN 27, 1967, and that death accurred of 7.35 M, from couses and on the date stated above. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING MED. DIRECTOR director, page 3 should be filed v 22d. ADDRESS 22c. PHYSTCIAN'S NAME (Type) 2705 MOUNTAIN RO-PASABENA 21122 CARLOS 23o. BURIAL, CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) REMOVAL (Specify) Feb.1.1967 Crossville City Cemetery Crossville. Temn 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Sinoleton Funeral Home 2So REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Glen Burnie, Md. DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH and 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY ANNE ARUNDEL ARUNDEL MARYLAND MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) hillurs 4 days ANNAPOLIS ANNAPOL IS 2 bon papers. within 72 h d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NAVAL HOSP (TAL RFD #5 Box 295 NO X etely NAME OF First Middle Last 4. DATE Month Year DECEASED event, 31 J0SEPH GEORGE NE IMAN (Type or print) DEATH 67 January 19 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED X NEVER MARRIED last birthday) Months 1 Days Hours in any Male Cauc. 1894 WIDOWED October | DIVORCED physician and please re 1Da. USUAL OCCUPATION (Give kind of work done | 1Db. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY and COUNTRY? NAVY RET Hickory Ridge, Pa. LT USN RET USA removal, 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending permit. Ther August Neiman Pauline Hirsch 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1 17. INFORMANT Address the attenit þ (Yes, no, or unkown) [(If yes give war or dates of service) RFD 5, Box 295 transit perm cremation, Anna E. Neiman (Wife) Annanoli INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH Š PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed l urial-tra JAJA Cenditions, If any, which been tlle by gave rise to Immediate <u>ء</u> د DUE TO cause (a), stating the as till prior underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY Arrer this certificate had be detached for use State Dept. of Health r PERFORMED? YES K NO [CERTIFI 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 2Dc. TIME OF INJURY Month, Day, Year 2Dd, INJURY OCCURRED | 2De. PLACE OF INJURY (Home, farm, | (State) 2Df. (City or town) (County) factory, street, office bldg., etc.) a: After Hour a.m. Not While at work While at work . 19 67 to_ 31 JAN . 19 67, that (I) (we) last 計 21. I certify that (I) (this hospital) attended the deceased from... 27 JAN DIRECTOR: 67, and that death occurred at 23.10M, from the causes and on the date stated above. Jan saw the deceased alive on 3 show 22a. SIGNATURE DATE SIGNED 22b. STAFF ATTENDING MED. DIRECTOR TO FUNERAL 22c. PHYSICIAN'S 22d. director, p should be 1 **ADDRESS** NAME (Type) ARENTZEN, CAPT BURIAL, CREMATION, 23b. 23c NAME OF CEMETERY OR CREMATORY 23d. LQCATION (City, town or county) (State) REMOVAL (Specify) 44 UNERAL DIRECTO REC'D BY REGISTRAR REGISTRAR'S SIGNATURE ADDRESS 25a. VR A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 hours after death puo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) physician and completely filled in by the funeral on please remove carbon papers. Pages I and a. COUNTY b. COUNTY a. STATE ANNE ARUNDEL MARYLAND ANNE ARUNDEL b. CITY DR TDWN (If outside corparate limits, c LENGTH OF STAY IN 16 c CITY OR TDWN (If autside corporate limits, write RURAL and give nearest tawn) 12 DAYS RURAL- PASADENA d, NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? NORTH ARUNDEL 113 MAGNOLIA AVE. YES NO XX 3. NAME OF First Middle 4. DATE Doy Last Month Year DECEASED MADELINE OAKES (Type or print) JANUARY 19 67 DEATH 9 AGE (In years IF UNDER 1 YEAR 1 IF UNDER 24 HRS. S SEX 6 COLOR OR RACE 7 MARRIED XX 8. DATE OF BIRTH NEVER MARRIED lost birthdoy) Months Doys WIDOWED DIVORCED OCTOBER 31.1897 FEMALE WHITTE 10o. USJAL OCCJPATIDN (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY CDUNTRY? HOUSEWIFE VIRGINIA TISA 14 MDTHER'S MAIDEN NAME 13. FATHER'S NAME Connell Karrena. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SDCIAL SECURITY NO 17. INFORMANT Address (Yes, na, ocunknown) (If yes give war or dotes af service) 215-32-6634 Alden W. Oakes -Same 25 18 CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART! DEATH WAS CAUSED BY INTERVAL BETWEEN burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TD Canditions, if any, which gave rise to immediate cause (a). DUE TO stoting the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital or offending TO FUNERAL DIRECTOR: After this certificate has been the WAS AUTDPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use Health p CERTIFICATION NO 20g ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18) detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame farm. (City or tawn) (County) (State) factory, street, office bldg, etc.) Nat While at work at wark 21. I certify that (1) (this hospital) attended the deceased from Dec. 28, 1966, to For P. 1966, that (1) (we) last saw the deceased alive an Jan 2 19 67, and that death accurred at 12:10MM, fram causes and an the date stated above 22b. DATE SIGNED 22a, SIGNATURE STAFF PHYS. director, page 3 should be filed w M.D. DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) (County) (State) 23a. BURIAL, CREMATION, 23b. DATE THEREOF BURENOVA (Specify) Glen Haven Memorial Pk. Glen Burnie, Md. Glan Burnie, Md. 2So. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Singleton Funeral Home/ 1967

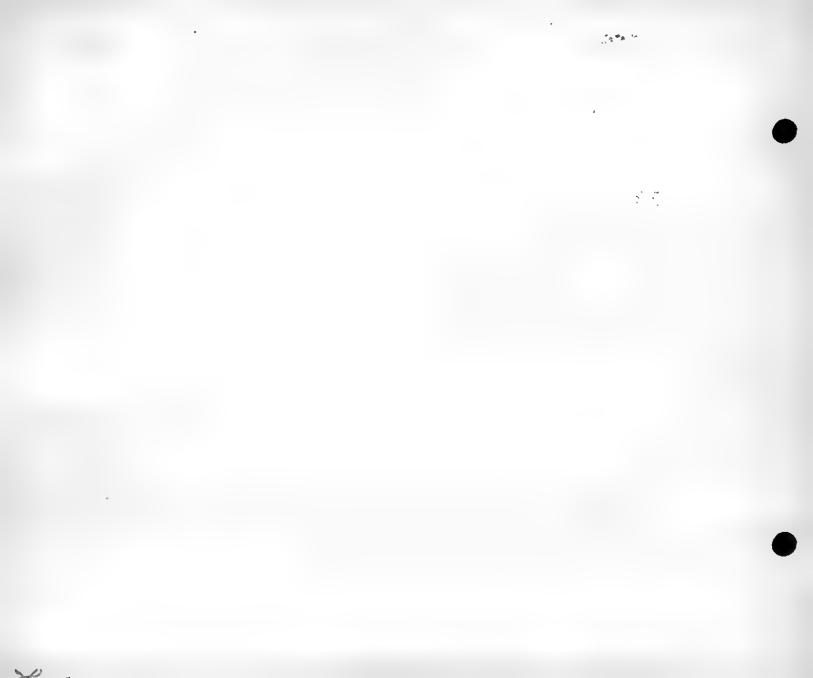


PARE OF DEATH PARE OF DEAT	1 / 8 / 1/ 3/	Division of STATISTICAL RESEARCH AND RECORDS, 301	W. PRESTON STREET, BALTIMORE, MARYLAN	D 21201
C. COINTY Anne Arundel MARY_AND D. STATE Maryland b. COLNTY Anne Arundel MARY_AND D. COLNTY Anne Arundel MARY_AND C. COLNTY Anne Arundel C. COLORS (In year) Annapolis d. Anna	FOR STATE	00157 MEDICAL EXAMINER'S C	ERTIFICATE OF DEATH	00153
Anne Arunde! Anne Arunde! MARYLAND Let But be composed to page of the second page nearest lown) Annapolis	HEALTH DEPT.	1 PLACE OF DEATH		Residence before odm ssion)
d MAME OF HOSPITAL OR INSTITUL ON (if no in hospital, give street address) Anne Arunde 1 General Rte. 5 Box 30 Control C	36 ge 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		o STATE Maryland b COUNTY	Anne Arundel
d MAME OF HOSPITAL OR INSTITUL ON (if no in hospital, give street address) Anne Arunde 1 General Anne Arunde 2 General Gertrude Owens Owens Owens Opens Op	dea	b CITY OR TOWN (IF outside carparate mits c LENGTH OF STAY IN 16	c C TY OR TOWN (flautside corporate mits write RURAL :	and give nearest town)
d MAME OF HOSPITAL OR INSTITUL ON (if no in hospital, give street address) Anne Arunde 1 General Rte. 5 Box 30 Control C	y de ann pM3. arrtm ter	Annapolis		0 x 1
DREATH 1 DO 16 67 SEX 6 CO.OR OR RAKE 7 MARRIED NEVER MARRIED DIVORCED DIV	20	d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address)	d STREET ADDRESS	e S RESIDENCE
DREATH 1 DO 16 67 SEX 6 CO.OR OR RAKE 7 MARRIED NEVER MARRIED DIVORCED DIV	F.27 5873	Anne Arundel General	Rte.5 Box 30	
Companies Comp	Page # 12		Lost 4. DATE Month	
Female Colored willower by the property of the	r de ve	(Type or print) Gertrude	Wens DEATH 1	10 19 67
Female Colored willower by the property of the	after a series of the series o	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8	DATE OF BIRTH 9. AGE (In years IF	
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PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20c TIME OF N.JRY Month, Doy, Year Hour o m. 19 of work of wo	thin ming	SAIHERS NAME	NO MOTHER'S MAIDEN NAME	
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PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20c TIME OF N.JRY Month, Doy, Year Hour o m. 19 of work of wo	ite, ta t	CAUC	Aut	opsy YES X NO
While Nor While of work of wor	= 2 0	206 EXTERNAL CAUSE WAS 206 DESCRIBE HOW INJURY OCCURRED (En	iter nature of injury in Part I ar Part I of item 1B)	
While Nor While of work of wor	ER: cert cert cert ces. es. shau	CAUSE OF DEATH.		
21 certify that I took charge of the remains described above, held an Autopsy x, Inspection , Inquiry , and in my opinion		20c TIME OF N.JRY Month, Day, Year 20d INJURY OCCJERED 20e PLACE While Not While foctory		(County) (State)
and the state of the fellows described obove, netd of Acords (E.), inspection (.), inspection (.), inspection (.), inspection (.)	XA Ute yau Yau d n	pm of work 🗀 of work		
deoth resulted from: Natural couses A. Accident J. Suicide J., Homicide J., Undetermined manner J. CHIEF MEDICAL EXAMINER J. ACTUAL ACTUAL SIGNED	= ×			
ACTUAL ACTUAL ACTUAL ACTUAL EXAMINER (CONTROL EX	Sign Sign	death resulted from: Natural couses ke , Accident [], Suicide		er 🔛
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DEPUTY MEDICAL EXAMINER 1/10/67	Y, P	SIGNATURE 1/2007/100 W. GAN	, 911; Ec.	- 1-0167
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DEPUTY MEDICAL EXAMINER Address (Street city town, or county) 1/10/67 230 BURG LERMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d JOCAT ON (City or Town) (County) (Stote)	Ssar fune fune NER th			1/10/6/
NAME (Type) Werner U. Sprtz, M.D. Address (Street city town, or county) 230 BUR AL (REMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR (REMATORY 23d NOCAT ON (City or Town) (County) (Stote)	o D D File		EMATORY 230 JOCAT ON (City or Town)	(County) (State)
Burial 1/14/67 Broadslet St. Margarets, mx.	5 - 3.5 - 1	131000 11/4/61 12/1000000	E St. Margar	els. mx.
VR A15ME (5) 24 FUNERAL DIRECTOR ADDRESS 250 REC D BY REG STRAR 250 (REGISTRAR S S GNATURE)	VR A15ME (5)	Milli (4)		

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· 1 (M)	Division of STATISTIC		PARTMENT OF HEALTH I W. PRESTON STREET, BALTIMORE, MA	RYLAND 21201
FOR STATE	00158	·	CERTIFICATE OF DEATH	00160
HEALTH DEPT.	PLACE OF DEATH G. COUNTY Anne Arunde1	MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if in a. STATE b.	stitut on Residence befare admission) COUNTY Anne Arunde1
Ti, 2, and 3 ta m PM3. Page Department of	b CITY OR TOWN (If auts de carparate limits, write RURAL and give nearest tawn)	c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outs de carparate limits, wrt	
orm P P Depo	d NAME OF HOSPITAL OR INSTITUT ON (If not be arm - Cumberst		d. STREET ADDRESS	e is residence on a farm? yes \tag{NO}
ofter death if a Give Pages 1, olong with form with the State Dewithin 72 hours	3 NAME OF First DECEASED (Type or print) HENRY	Middle	Last 4 DATE OF DEATH	Manth Day Year 1 4 19 67
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within 24 pencir in caminer's le pages and in any	13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Axecuted will nding" in pe Medical Exar permit. File	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give war ar dates af si		INFORMANT	Address
be e "pel	18 CAUSE OF DEATH (Enter on y one couse PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Near Contact Shotg	un Wound of Chest	INTERVAL BETWEEN ONSET AND DEATH
is certificote should be e e, writing the word "per forwarded to the Chief i e used os a burial-transit o buriol, cremotian, or re	Conditions, if any, which gave (b) rise to immediate couse (a), DUE TO			
rifficote rifing th rarded i rad os a	last. (c)		THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) I9 WAS ALTOPSY
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IINER: T should b files. 3 should ent, prior		Shot Self in Ch	est ACE OF INJURY (Hame, farm, 20f (City or tow	
MECCAL EXAMINER: This operate a secure the certificate, director Poge 4 should be for your files. DIRECTOR: Page 3 should be to the designated ogent, prior to the testing of the testing	8:00 Hour a m 1 4 19 6	ten i mandel de " " fore	tory, street, affice bldg , etc.) Barn	Anne Arundel Md
se exeestar Pertar Pert			cide X Hamicide , Undetermine	
DEPUTY MECHAL EXAM stessory, pleose execute the funeral director Poge 4 may be retained for your FUNERAL DIRECTOR: Page eath or its designated age	ACTUAL SIGNATURE LACEL	11	M.D ASSISTANT MED CAL EXAMINER X DEPUTY MEDICAL EXAMINER	22. DATE SIGNED
TO DEPUTY MEDICAL EXAMINER: This necessory, please execute the certificate, the funeral director Page 4 should be for 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be Health or its designated agent, prior to	NAME (Type) Charles S.		Address (Street, city, tawn, ar caunty) CREMATORY 23d LOCATION (City	1/5/67 ar Town) (County) (State)
- = (X)	REMOVAL (Specify) 1 — 12 24 FUNERAL DIRECTOR	1-67 V.O. M.d. Wood	1. School Ballin 25a. REC'D BY REGISTRAR 25	
VR A15ME (6) 1 6M 1/68			DATE JAN 13 1967	y Charles Jus



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 2 USUAL RESIDENCE (Where deceased lived, funstitution Residence before admission) PLACE OF DEATH o. COUNTY n STATE b. COUNTY P.M3. Page with the State Department of Anne Arundel Maryland MARYLAND Anne Arundel b CITY OR TOWN (If outside corporate I mits, c LENGTH OF STAY IN 16 c CITY OR TOWN (f outside carporate limits, write RURAL and give negrest town) write RURAL and give nearest town)
Edgewater Edgewater d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RES DENCE ON A FARM? form 11 Beach Drive, Selby Bay Beach Drive, Belby Bay NO 🖂 Item 18 Give Pages Office along with NAME OF Middle 4 DATE OF Month Dov Year DECEASED PARRISH F. 23 67 January (Type or print) DEATH 19 IF JNDER 24 HRS SFX AGE (In years IF UNDER I YEAR 6 COLOR OR RACE 7 MARRIED DATE OF BIRTH NEVER MARRIED Months Hours Male WIDOWED D-VORCED. White 100 USJAL OCCUPATION (Qive kind of 12 CITIZEN OF WHAT ⊆ Chief Medical Examiner's pencil 1 13 - FATHER'S NAME within 72 haurs ⊑ WAS DECEASED EVER IN J.S. ARMED FORCES? 16 SOC AL SECUR TY NO 17., INFORMAN permit. I (Yes, hor or unknown) (If yes bive war ar dates of service) 421-30-3403 pending INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c) burial-transit event 1 ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication and Massive Body certificate shauld e, writing the ward farwarded to the Ch XXXXXXX Burns. dny Conditions, if ony, which gove rise to immediate cause (o), .⊑ DUE TO stating the underlying couse pup remaval, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY CERTIFICATION PERFORMED? certificate, YES 🔀 NO. 200 EXTERNAL CAUSE WAS PRIMARY 23 OF CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of njury in Port I or Part II of Item 18.) 3 shauld shauld þ Conflagration CAUSE OF DEATH cremation, MEDICAL 20d INJURY OCCURRED (City or fown) 20c TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Mome form (Stote) please execute the foctory, street, office bldg , etc.) Hour 35.36 Not While X may be retained for your FUNERAL DIRECTOR: Page 1/23Edgewater Md. 19 67 ot work Α.Α. 21. I certify that I taak charge of the remains described above, held an Autapsy [x] inspect an Inquiry | and in my apinian death resulted fram: Natural causes Accident 🔀 Suicide Hamicide Undetermined manner director CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER 🔀 prior **SIGNATURE** funeral 1/24/67 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health Charles S. Petty NAME (Type) Address (Street, city, town, or county) (County) a(Stote) 0 REGISTRAR'S SIGNATURE VR A15ME (5) 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00160 CERTIFICATE OF DEATH 00162 requires that the death certificate be executed within 24 hours after death. by the funeral Pages 1 and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY A.A. ACOUNTY Anne Amindel o. STATE Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits. C. LENGTH OF STAY IN 15 c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town) 3 days Severn Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitor, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Box 139B North Arundel Hospital YES W NO [3. NAME OF Middle Lost 4 DATE Month Dov DECEASED 0F S 27 Patrick January Charles (Type or print) DEATH S SEX IF UNDER 1 YEAR IF JNDER 24 HRS. 6 COLOR OR RACE 7. MARRIED TO NEVER MARRIED B. DATE OF BIRTH 9 AGE (In years lost birthdoy) 20_87 7/30/86 WIDOWED DIVORCED 1Do USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 1). BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even fretired) USA USA INDUSTRY Virginia Ret. Farmer Ret. Farmer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME E E Sally Hess James R. Patrick 15. WAS DECEASED EVER IN J.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 227-05-9797 Mrs. Paul B. Bonovich, Gettysburg, Pa. R-1 18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).) INTERVAL BETWEEN signed by the buriol-transit p PART I. DEATH WAS CAUSED BY: DASET AND DEATH wort farlun IMMEDIATE CAUSE (o). DUE TO A. S. C. U. Q. Conditions, if ony, which gove rise to immediate couse (o), DUE TO storing the underlying couse os the prior to O FUNIRAL DIRECTOR: After this certificate has been last 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES T NO F و 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 200 ACCIDENT WAS UNDERLYING [2] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 2Dc TIME OF INJURY Month, Doy, Year 2Dd. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) (State) Hour o.m. factory, street, office bldg., etc.) Not While at work 21. I certify that (I) (this haspital) attended the deceased from tend to 1966 to Jan. 21, 1967, that (I) (we) last saw the deceased alive on 1967, and that death occurred at 735 pM, from causes and an the date stated above. 220. SIGNATURE 22b. DATE SIGNED MED.
DIRECTOR STAFF PHYS. 1-27-67 M.D. 22d. ADDRESS 22c PHYSICIAN'S ROBERT DABOLINA, MD 400 CRAIN HWAY NIN Then Bening ad. NAME (Type) director, should b 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BUR-AL, CREMATION, PEMOVAL (Specify) 1/31/67 Bel Air Memorial Gardens Bel Air, Harford Co. Md. 25b. REGISTRARS SIGNATURE Judge 25o. REC'D BY REGISTRAR Littlestown, Pa, DATE JAN 30 20 M 1/66

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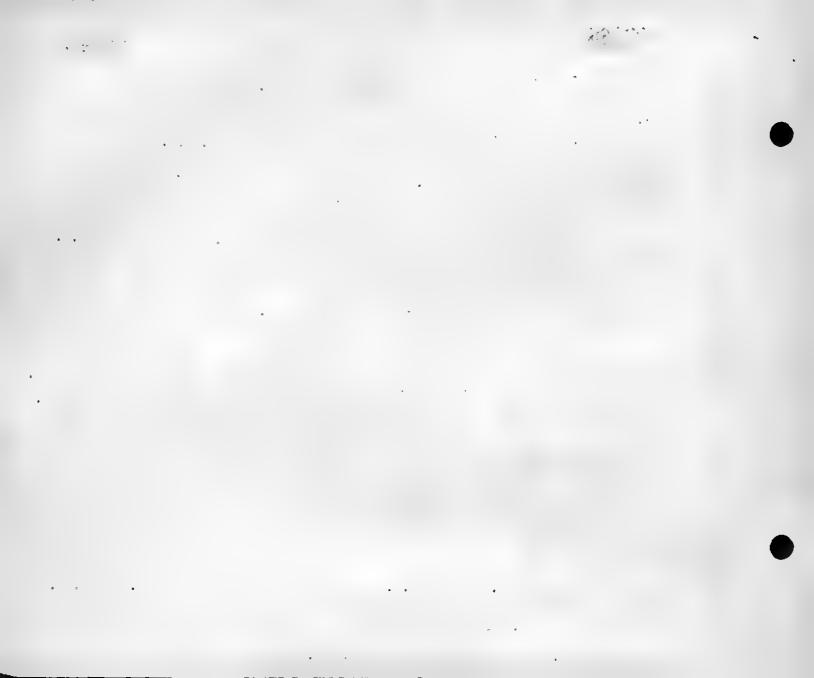
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. hours after death, PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY Anne Arundel Anne Arundel Maryland physician and completely filled in by the 1 n please remove carbon papers. Pages 1 /al, and in any event, within 72 hours after MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Annapelis ever 30 yrs. Annapolis d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) B. IS RESIDENCE ON A FACING d. STREET ADDRESS 72 Clay Street 72 Clay Street deathreertificate be executed within First Middle DATE Month Day Last DECEASED 19 67 THOMAS PERRY DEATH Jan. 5 (Type or print) NMN 5. SEX ACE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months Days Hours Jan. 3-1894 WIDOWEDIA Male Negro DIVORCED [10a. USUAL OCCUPATION (Give kind of work done | 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Construction Laborer Virginia 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME Unknown Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address 0 (Yes, ng or unkown) | (If yes give war or dates of service) been signed by the atte the burial-transit permit or to burial, cremation, or Anna Belle Johnson-Ill Obery 214-05-1822 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN PHYSICIAN: The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). the hospital or attending physician. UNGS AND ADDOMINAL **DUE TO** Conditions, If any, which (b) gave rise to immediate as the l DUE TO cause (a), stating the underlying cause last. CERTIFICATION WAS AUTOPSY PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) r this certificate h detached for use te Dept. of Health for use Health PERFORMED? ND YES [DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dc. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) (County) (State) 2Dd. INJURY OCCURRED 20f. (City or town) Hour a.m. While at work After Id be d Not While at work p.m. retained DIRECTOR: A age 3 should lled with the S 21. I certify that (I) (this hospital) attended the deceased from that (I) (we) last LCM, from the causes and on the date stated above. saw the deceased alive on. and that death occurred at // 1 22a. SIGNATURE 22b. DATE SIGNED page . ATTENDING PHYS. DIRECTOR M.D. HOSPITAL PHYSICIAN'S NAME (Type) ADDRESS FUNERAL 22c. director, p 1407 Forrest Drive Annapolis, Md. A.L.KISO 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) 23b. DATE THEREOF 23a. BURIAL, CREMATION, REMOVAL (Specify) Annapelis, Maryland Brewer Hill Jan. ADDRESS REC'D BY RECISTRAR | 25b. RECISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR C.E.Hicks Ill Ammapolis, Md. A15 (4) 2DM 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

O018 00162 00164 requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH a. COUAIN NE 2. USUAL RESIDENCE (Where deceased fived, if institution: Residence before admission) ARUNDEL a. STATE b. COUNTY ANNE ARUNDEL MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, write RURAL and give pearest town) 1 month IS RESIDENCE ON A FARM? d NAME OF HOSP TALOR INSTITUTION (If not in baspital, give street address)
NORTH ARUNDEL HOSP LTAL d. STREET ADDRESS 117 CRAIN HWY. N.E. YES NO K 3 NAME OF Middle 4. DATE First Last Yest 7 DECEASED 0F PHELPS WILBUR 19 (Type or print) DEATH IF UNDER 24 HRS. DATE OF BIRTH IF UNDER YEAR 5 SEX 6 COLOR OR RACE 7 MARRIED A AGE (In years NEVER MARRIED lost birthday) Months Davs 16-93 Haurs WIDOWED DIVORCED 10a JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
RETIRED— BAR OWNER BROOKLYN. MD. Empolyed 12 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Rufus D. Mollie Cromwell (unknown) Phelps CUDISDOM? burial-transit permit. The burial, crematian, or remo 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, na, ar unknown) (If yes give war or dates of service) (Wife) Mrs Ruth M. Phelps 216-28-9924 Same as #2 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for COUTE) and WASTRIC DILATATION PART I DEATH WAS CAUSED BY HIAS QUALITY OF THE STATE OF TH IMMEDIATE (AUSE (a) GENERALIZED CARCINOMATOSIS DUE TO Canditians, if any, which gave rise to immediate cause (a), 3 MOS. (b) RHABDOMYOSARCOMA DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been be detached far use as the State Dept. af Health priar ta 1 YR. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 200. ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (County) (State) Hour am Not While factory, street, affice bldg., etc.) at wark 21. I certify that (I) (this hospital) attended the deceased fram 12-5-66 . 19 ___, that (I) (we) last . 19 7-23-67 . ta saw the defeased alive an 1-23-67 19 ____, and that death accurred at 1 : 10pM, from causes and an the date stated above 22b DATE SIGNED 22g SIGNATURE ATTENDING STAFF PHYS. 1-23-67 DIRECTOR M.D. 22d ADDRESS 22c. PHYSICIAN'S 614 MEDICAL ARTS BDLG. BALT. MD. NAME (Type) BERMAN. M.D. MAURICE 23a BURIAL, CREMATION, REMOVAL (Specify) 23d. LOCATION (City or Town) 23c. NAME OF CEMFTERY OR CREMATORY (County) 23b. DATE THEREOF (State) Haltimore, Maryland
STRAR 25b. REGISTRAR'S SIGNATURE Jan. 26, 1967 Baltimore Nat'l Cemeterly
ADDRESS 1250. RECD BY REG 25a. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) "d. Glen Burnie. DATE JAN Richard V. Singleton



Tage + indy be retained by the property of the property of the property of the funeral director, page 3 should be detached for use as the burial-transit permits in a please remove carbon papers. Pages, 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, ox. removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
OP165

П	_	Charles and Charles	ORIGINI TOATE	. OI DEATH		UU1407						
П	1.	PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (WI	nere deceased lived, If instit	ution: Residence before admission)						
1		Anne Arundel	MARYLANO	a. STATE Maryla	nd b. count	Anne Arundel						
ľ		b. CITY DR TOWN (if outside corporate limits.	c. LENGTH OF STAY IN 1b	•		RURAL end give nearest town)						
1		write RURAL and give nearest town) Annapolis	life	Annapelis		12.1						
ı		d. NAME OF HOSPITAL OR INSTITUTION (if not in h	ospital, give street eddress)	d. STREET ADDRESS e. IS RESIDENCE								
		208 Eastern Avenue		208 Eastern	ON A FATTM? YES ND							
1	3.	NAME OF First DECEASED	Middle	_	DATE Month	Oay Year						
1		(Type or print) ROBERT EDW		0-0		.0 19 67						
ı	5.	SEX 6. CDLOR OR RACE 7. MARRIED	MEACH HIMARIEO	. OATE OF BIRTH		UNDER 1 YEAR IF UNDER 24 HRS. onths Oays Hours Min.						
	-	ale Negro WIOOWED		ar. 22-1894	72 yrs. "							
1	1Da dur	USUAL OCCUPATION (Give kind of work done 10b. king most of working life, even if retired) Construction Laborer - re	CIND OF BUSINESS OR NOUSTRY CUITED	11. BIRTHPLACE (County &		12. CITIZEN OF WHAT COUNTRY?						
		FATHER'S NAME	Police			U.D.R.						
1	13.	FATHER'S NAME		14. MOTHER'S MAIDEN NA								
1	4.5	Rebert E. Pindell Sr	- 1	Carrie ?								
1	15. (Ye:	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT Address Address 214-05-1880 A Birdie H. Pindell-208 Eastern Ave.										
ŀ		NO 2	14-07-1000 M	TLATE U. LTMME	Annapolis.	Md						
ľ	1	18. CAUSE DF DEATH [Enter only one cause per l	ine for (a), (b), and (c).]	11 -1.	-/ /	INTERVAL BETWEEN ONSET AND DEATH						
1	-1	PART I. OEATH WAS CAUSEO BY:	neway,	1 Practa	(west	1 OHOLI AND DEATH						
ı	-1	///X OUE TO	7.1.1	+ 1 . 1								
ì	(conditions, if any, which) (b) we lacked to the argions											
1	- 1	gave rise to immediate (
1	- 1	cause (a), stating the OUE ID underlying cause last. (c)										
۱	ᅙ	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB	UTING TO OFATH BUT NOT RELAT	ED TO THE TERMINAL OISEAS	ECONOITION GIVEN IN PA	RT1(a) 19. WAS AUTDPSY PERFORMED?						
7	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 2Da. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Part II of Item 18.) 3Da. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Part II of Item 18.) 3Da. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Part II of Item 18.) 3Da. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Part II of Item 18.)											
1	띩	2Da. ACCIDENT WAS UNDERLYING 20b.	DESCRIBE HOW INJURY OCCUR	REO. (Enter nature of injury	y In Pert I or Part II of I	tem 18.)						
1	8	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
١			NJURY OCCURRED 20e. PLAC	E OF INJURY (Home, farm,	20f. (City or town)	(County) (State)						
1	MEDICAL	Hour a.m. While	- Not While - factor	y, street, office bldg., etc.)		, , , , , , , , , , , , , , , , , , , ,						
1	ΞĮ	p.m. 19 at wor										
1	- 1	21. I certify that (I) (this hospital) attend		,		, 19, that (I) (we) last						
ı		saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.										
		ZZZZ. SIGIRATORE	M.D.		TOR PHYS.							
4	l	22c. PHYSICIAN'S NAME (Type) A.T.Allen		22d. AOORESS Cather	iral St. Anna	apelis, Md.						
	23a	BURIAL, CREMATION, 23b. OATE THEREOF REMOVAL (Spimify)	23c. NAME OF CEMETERY		d. LOCATION (City, town							
		REMDVAL (Spelfy) Jan. 14-67	Pine Lawn		Bestgate Rd.	Annapolis, Md						
24. FUNERAL DIRECTOR ADDRESS 25a. REC'O BY REGISTRAR 25b. REGISTRAR'S SIGNATURE												
C.E. Hicks 111 Annapolis, Maryland DATE JAN 17 1967 Schooles Judget												
- 1				DOME ALTER								

VR AI5 (4) 20M 1/65



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27	0.		Arundel Co.			MARYLAND	a. STA	Md.		d lived, if instit. b. CO	UNTY A.	A.Co.	
			Durnie (arparote limits, liven)		15 Day		Во	x 352	Blvd.	limits, write R Park, P		a,A.A.	Md.
27	d	North A	or insutjuon of not rundel host	n haspital, gi	ve street address)	< -	Ho	spital		Glen Bu	rnie,	Md e. IS ON YES	RESIDENCE I A FARM? NO DE
		EASED be ar print)	Robert		Middle E.	Rave	1	ost Sr.	4. DATE OF DEATH	Jan		Daγ 28	Year 1967
	5 SEX Ma	le	White	WIDOWED		RCED 5		/1900	6.	AGE (In years lost birthday) yrs		1 Doys Ho	JNDER 24 HRS. Burs Min
	during	WAL OCCUPATION (6 most of warking life Superv: THER'S NAME	ove kind of work done e, even if refired)	IND	ND OF BUSINESS OF			HPLACE (County altimo HERS MAIDEN I		-	12, CO CO	T ZEN OF WH UNTRY?	A
moval, and i		Joseph	Ravel		OCIAL AVGURDAN			War					
a, ar		No.	N U.S. ARMED FORCES? Yes give war ar dates af s	21	0CIAL SECURITY N 8-03-7		NFORMAN NFORMAN		vel (Wife)	lress As	Associated in Contrast of the	/e
ematia	1.	PART DEATH	TH (Enter only one couse WAS CAUSED BY IMMEDIATE CAUSE (a	/	(a), (b), and (c) s	a	Del						L BETWEEN AND DEATH
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ž 2	st lo	oting the underly	ing couse (c			<u> </u>							
. 2	ATION	ART II. OTHER SIGN	IIFICANT CONDITIONS CON	TRIBUTING T	O DEATH BUT NOT	RELATED TO T	HE TERMIN	NAL DISEASE COI	NDITION GIVEN	I IN PART I(a)		19. WAS PER YES [S AUTOPSY FORMED? NO
2		DO ACCIDENT WAS U R CONTRIBUTING C F EITHER, NOTIFY M	I CAUSE OF DEATH	205. DES	CRIBE HOW INJUR								
	MEDICA	Havr a.m. p.m.	Y Manth, Day, Year 19	While at wark	JURY OCCURRED Nat While at work	focto	ory, street,	RY (Hame, farn affice bldg., etc.		(City or town)	,	unty)	(State)
e all		saw the dec	that (I) (this hospi eased alive on	tal) attend	led the decea	sed fram , and that	death	accurred at	, to	, from cause	s and an t	he date st	(I) (we) las tated abave
htiw be		220 SIGNATURE	NI	SI	W	7 м.с		يا	MED. DIRECTOR	STAFF PHYS.	22b. C	ATE SIGNED	
director, page 3 should be detached for use as the burial-transit permit. Then of should be filed with the State Dept. of Health prior to burial, cremation, ar removal,		224. PHYSICIAN'S NAME (Type)				un.		ADDRESS					
shaul	E	BURIAL, CREMATION REMOVAL (Specify) Burial	23b DATE THER 1/31/		23c. NAME OF Cedar ADDRESS	CEMETERY OR C			Bro	ATION (City or	A. A	(County)	(Stote)
5 (4)		uneral director	C. Fink	G.	ADDRESS Len Bur			2Sa. REC'	D BX SECISIES	1 1967	REGISTRAR	are ey	Judge



MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00166 CERTIFICATE OF DEATH 00168 and 2 death. requires that the death certificate be executed within 24 hours after death by the funeral Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH a. COUNTY a. STATE Marvland Anne Arundel and campletely filled in by the fur remave carban papers Pages 1 in any event, within 72 haurs after MARYLAND b CITY OR TOWN (If outside corporate mits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town)
Lrownsville 4 months Piney Point d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? Crownsville State Hospital St. George Island YES NO 3 NAME OF Middle Last DATE Month Year First Day DECEASED #33254 OF DEATH Norman I. Rice B DATE OF BIRTH 9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 73 last birthdoy) Doys Haurs 10/18/93 Male White WIDOWED | DIVORCED 11 BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT 10o USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) INDUSTRY Marvland USA Ovster Business 14. MOTHER'S MAIDEN NAME Charles Rice G- TOTAL TOTAL the attending 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor ar dates af service) INFORMANT 16 SOCIAL SECURITY NO. signed by the attend burial-transit permit. Hospital Records Unknown INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for $\{a\}$, $\{b\}$, and $\{\epsilon\}$, ONSET AND DEATH PART I DEATH WAS CAUSED BY: Bronchooneumonia IMMEDIATE CAUSE (o) by the haspital or attending physician. DUE TO Conditions, if any, which gove rise ta immediate couse (a), DUE TO stating the underlying couse has been be detached far use as the State Dept. of Health priar ta PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Chronic Brain Syndrome sec. Arteriosclerosis NO 🔨 O FUNERAL DIRECTOR: After this certificate 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Part II af item 18.) 20a. ACCIDENT WAS UNDERLYING . OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year foctory, street, affice bldg., etc.) Nat While at work 9/9/___, 19_66, to_ 1/9/ , 1967 , that (I) (we) last 21. I certify that (I) (this/hospital) attended the deceased from O HOSPITAL OR ATTEND Page 4 may be retained director, page 3 should should be filed with the 1/9/___19_67, and that death occurred of 10: PM, from causes and an the date stated above saw the deceased alive on A 22b. DATE SIGNED 22o. SIGNATURE 1/10/67 X M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Crownsville State Hosnital Beriedict. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City or Tawn) (State) (Caunty) 23b. DATE THEREOI 23a. BURIAL CREMATION. 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR



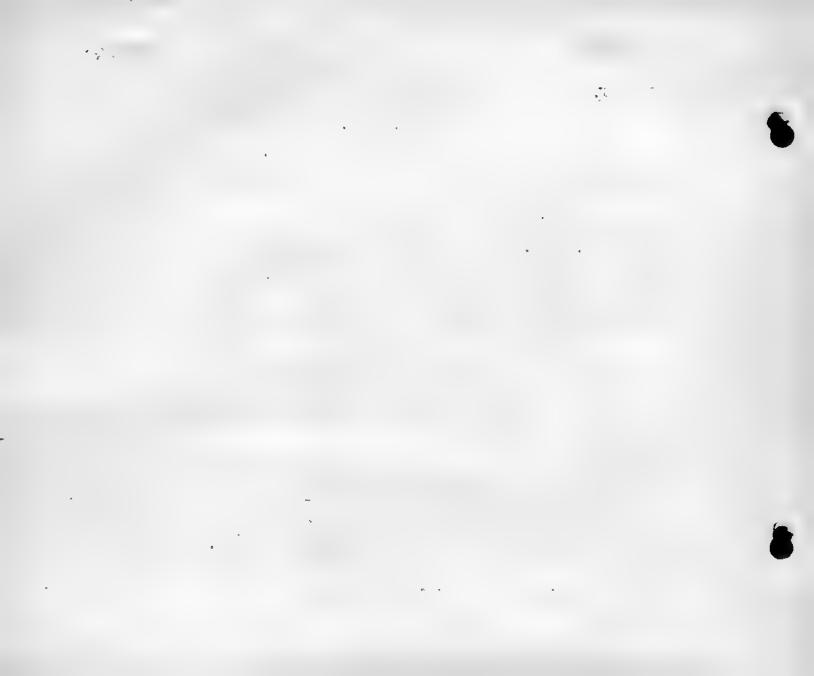
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00167 CERTIFICATE OF DEATH 00169 The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE h. COUNTY ease remove carbon papers. Poges 1 ond in ony event, within 72 hours after (If outside corporate limits E LENGTH OF STAY IN 16 c CITY OBSTOWN (If outside corporate limits, write RURAL and give negrest town) e IS RESIDENCE ON A FARM? OR INSTITUTION (If not in hospital, give street address) RSIN YES NO Z NAME OF Middle DATE First Dov Lost Year DECEASED ROANE, Sr. Henry Nelson (Type or print) DEATH 19 5 SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS B DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months White Jan. 25. 1882 Mala WIDOWFD DIVORCED KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10o USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? Virginia DWARE LUMBER 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME buriol, crematian, or removol, WAS DECEASED EVER IN DS ARMED FORCES? INFORMAN' 36. SOCIAL SECURITY NO. (Yes, no, or unknown) I(If yes give wor or dates of service) IB CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-tronsit p ONSET AND DEATH IMMEDIATE CAUSE (o' DUE TO Conditions, if any, which gove use to immediate couse (a). **DUF TO** stating the underlying couse as the of Health prior to WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES [NO b 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20a ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CLAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 should be detoche should be filed with the Stote Dept 20e PLACE OF INJURY (Home, form, 20f (City or town) (State) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (County) O FUNERAL DIRECTOR: After this ED! Hour o.m. foctory, street, office bldg., etc.) Not While at work 19____, that (I) POE) last 2]. I certify that (I) (the board) attended the deceased from 19 saw the deceased alive on____ and that death accurred at M, fram causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. PHYS. ADDRESS 22c. PHYSICIAN Hahn ProfBldg., Severna Park, Md. NAME (Type) Ray M. Smith, M.D. BURIAL, CREMATION NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Tawn) (County) (State) 2501 REC'D BY REGISTRAS DATE

" Cara

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00170 cecuted within 24 hours after death. completely filled in by the funeral love corbon papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY o. STATE **b** COUNTY MARY! AND c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits c CITY OR TOWN autside carporate limits, write RURAL and give negrest town oon papers. Pag within 72 hours EMS e. IS RESIDENCE ON A FARM? d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) OA NO 💢 DATE NAME OF Eirst Middle Lost Day Year DECEASED OF (Type or print) DEATH 19 S SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years please remove 88 birthday Months Days Hours WIDOWED DIVORCED and in ony 10a USUAL OCCUPAT ON (Give kind of work done 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, eyan if retired) INDUSTRY COUNTRY P physician requires that the deoth certifical 13 - FATHER'S NAME MOTHER'S MAIDEN NAM 14 or removal. the attending physical result. Then f WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. INFORMANT Address (Yes, no, or ynknown) (If yes give war ar dates of service) cremation. INTERVAL BETWEEN ONSEL AND DEATH CAUSE OF DEATH (Enter only one cause per ling for (a), (b) and (c).) buriol-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) O FUNERAL DIRECTOR: After this certificate has been signed by Page 4 moy be retained by the haspital or attending physician. DUE TO buriol. Conditions, if any, which gave rise to immediate couse (o), DUE 1D for use os the t f Heolth prior to b stating the underlying cause last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO 20g ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH of detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED factory, street, affice bldg., etc.) Hour om. While Not While þe 19570 to 3 1 1 mm/, 1962, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from... should and that deoth accurred of 032PM, from couses and on the date stated above saw the deceased plive on SIGNATURE 22b. DATE SIGNED 22a ATTENDING M D PHYS DIRECTOR PHYS filed r, poge be filed ADDRESS 22e PHYSICIAN S NAME (Type) director, should **8UR AL, CREMATION** 23b. DATE THEREOF 23G NAME OF CEMETERY OR CREMATOR LOCATION (City or Town) (County) RRAINE REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 2Sa VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00169 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death ond completely filled in by the funeral regions carbon papers. Pages 1 and 3 in any event, within 72 hours after death I PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fived, if institution. Residence before admission). o COLINTY b. COUNTY Maryland Anne Arundel MARYLAND c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside carporate imits, write REPART and plvs peget 100) Baltimore 11mns.15das d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Crownsville State Hospital 703 E. Chase Street YES NO XC 3 NAME OF First Middle 4 DATE Lost Month DECEASED (Type or print) 1967 Roundtree #31153 James DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years 7 MARRIED NEVER MARRIED 7 (ost birthdoy) Davs Hours 2/5/1896 WIDOWED 5 DIVORCED Negro Male 10o USUA, OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign (ountry) 12 CITIZEN OF WHAT and in c COUNTRY? lease Radio Tech. (ret. INDUSTRY USA North Carolina 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, Nancy Martin Roundtree signed by the attending p buriol-tronsit permit. The buriol, cremation, or remo IS. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) [(If yes give wor or dotes of service)] 16 SOCIAL SECURITY NO 17. INFORMANT Address Hospital Records Unknown No INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bronchopneumonia IMMEDIATE CAUSE (a) ottending physicion DUE TO Cerebrovescular Accident Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse has been be detached for use os the State Dept. of Health prior to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Chronic Brain Syndrome - Inanition and Diabetes Mellitus YES 🗀 NO O FUNERAL DIRECTOR: After this certificate Page 4 may be retained by the hospital or 205 DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port 1 or Port II of item 18.) 200 ACC DENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! (Stote) 20d. INJURY OCCURRED 20e PLACE OF INJURY (home, farm, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While ATTENDING 21. I certify that (I) (this haspital) attended the deceased fram. 1/5/ , 1967, that (I) (we) last director, page 3 should should be filed with the 1/5/_ 1967 , and that death accurred at 1:30 M, fram causes and an the date stated above saw the deceased alive on 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. ATTENDING 1/5/67 M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S Crownsville State Hospital, Md. NAME (Type) Benedict 23d. LOCATION (City or Town) #3c. NAME OF CEMETERY OR CREMATOR) (County) (Stote) 230. BURIAL, CREMATION 23b. DATE THEREOF REMOVAL (Specify) REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Vilianles & 20 M 1/66 CL 175 14

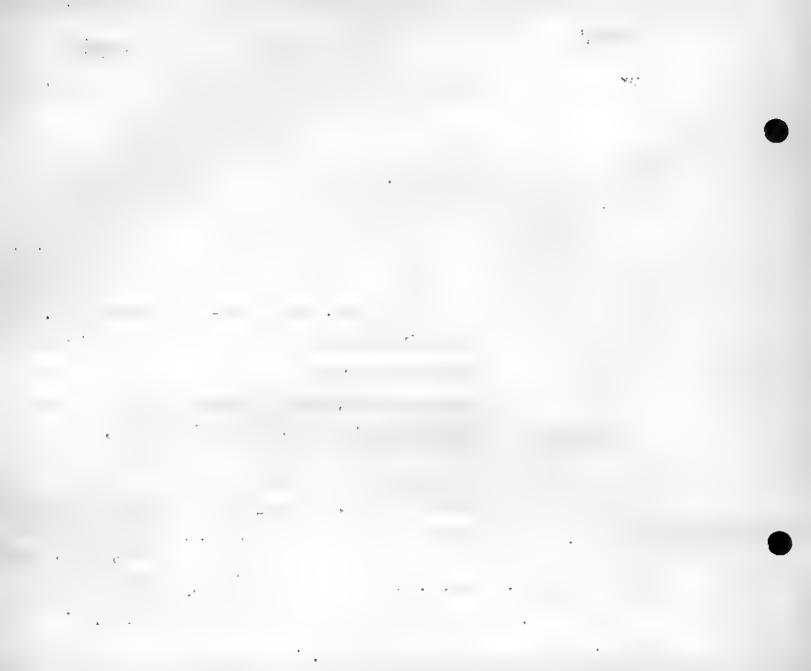


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ficate be executed within 24 haurs after death physician and completely filled in by the funeral PLACE OF DEAT 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) n COUNTY o STATE **b** COUNTY please remave carban papers. Pages 1 MARYLAND b CITY OR TOWN (If outside carparate limits, c JENGTH OF STAY IN 16 autside corporate limits, write RIJRAL and give negrest town) Onte RURAL and give negrest town) d NAME OF HOSPITAL OR INSTITUTION. (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? NOTE: NAME OF Middle First DATE Year Doy DECEASED OF DEATH Type or pant 196 SEX AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE NEVER MARRIED IF UNDER 24 HRS kist-birthday Manths Days Hours WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10a USUAL,OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT during ground of working life, even if retired) INDUSTRY COUNTRY? ME-13. FATHER'S NAME the attending phy sit permit. Then A6. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) crematian, 1B. CAUSE OF DEATH (Enter only one cause per incedor INTERVAL BETWEEN burnal-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) TO FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO as the stating the underlying cause Page 4 may be retained by the hospital or attending Health priar to last. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use NO TA 2Do ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 should be detache should be filed with the State Dept. 2Dc. TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED 2De, PLACE OF INJURY (Home, form, (State) (City or town) (County) Haur a.m factory, street, office blda, etc.) Not While 21. I certify that (I) (this hospital) attended the deceased from 2 - 12 -1965 that (I) (we) last saw the deceased alive an Al Certifie 19 65, and that death accurred at M, fram causes and an the date stated above. 22a. SIGNATURE **DATE SIGNED** 22Ь. ATTENDING M.D. PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 230. BURIAL, CREMATION: 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATIORY **ŁOCATION** (City or Jown) (fauroy) 2Sb. REGISTRAR'S SIGNATUR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 0017; PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Residence before odm spion) de de PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution o. COUNTY o. STATE **b.** COUNTY ond completely filled in by the fun remove carbon papers. Pages 1 n any event, within 72 hours ofter o Anne Arundel MARYLAND Maryland Anne Arupuel b CITY OR TOWN (If outside carporate Finits, write RURAL and give nearest town)
Annapolis c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) r LENGTH OF STAY IN 16 MVVVers///Xe N. Linthicum d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? Annapolis Rd. Anne Arundel General Hospital Mood /Nurs/inv/ Home YES NO NAME OF First and in any event, wit Year DECEASED (Type or print) W. Ethel SAVAGE DEATH January 19 67 IF UNDER LYFAR S SEX 6, COLOR OR RACE 8. DATE OF BIRTH 9. AGE (in years IF LINDER 24 HRS 7 MARRIED **NEVER MARRIED** last birthdoy) Months January 17,1880 WIDOWED X DIVORCED White Female. 10o USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1). BIRTHPLACE (County & State or foreign country) 12. CIT.ZEN OF WHAT physicion o during most of working life, even if retired) **COUNTRY? INDUSTRY** Housewife

13. FATHERS NAME U. S. Virginia
14. MOTHER'S MAIDEN NAME John West Sadie Bundick signed by the otteneing buriol-tronsit permit in burial, cremotion, or re-15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dates of service) Mrs. Nancy Keesev- 24 Old Annapolis Rd CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure Page 4 may be retained by the hospital or attending physician. DHE TO Conditions if ony, which gove Myocardial infarction 4. months nse to immediate couse (a), DUE TO stating the underlying couse os the PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G VEN IN PART I(0) WAS AUTOPSY PERFORMED? detached for use te Dept. of Health Arteriosclerotic nephrosclerosis with uremia. esophageal stricture. NO -O FUNERAL DIRECTOR: After this certificate bronche preumonia pleural of fusion
30 ACCIDENT WAS UNDERLYING - 20b. DESCRIBE FLOW INDURY OCCURRED (Enter noture of injury in Port 1 or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, ((ity or town) 20c. TIME OF INJURY Month, Day, Year ((ounty) (Stote) foctory, street, office blda, etc.) Not While 21 I certify that (1) (this haspital) attended the deceased from 13 December 1966, to 4 January 1967, that (1) (we) last saw the deceased alive on 1 January 19 67, and that deoth occurred at M, from causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR STAFF PHYS. January 1967 M.D. PHYS. 22c. PHYSICIAN'S 22d. ADDRESS South River Medical Center NAME (Type) Charles W. Kinzer, M. D. Edgewater Maryland 21037 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or lown) omac (County) 23o. BURIAL, CREMATION 23b DATE THEREOF (Stote) REMOVAL (Specity) Jan. 7.1967 Wachapreague Cemetery Wachapreague, George J. Gonce-4001 Ritchie Hgwy., Baltimore, VR A15 (4) 25M 1/67



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) . A. COUNTY **b. COUNTY** a. STATE MARYLAND ANNE ARINDEL MARYLAND b. CITY OR TOWN (if outside corporals limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) ANNAPOLIS, FARYLAND ANNAPOLIS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? ARUNDEL GENERAL HOSPITAL treat YES NO T 3. NAME OF Middle 4. DATE DECEASED OF THERESA (Type or print) ELIZABETH SHARPS DEATH 1967 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years I IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days REMALE WIDOWED | DIVORCED V ICa. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or fore on country) 1 12. CITIZEN OF WHAT COUNTRY? done during most of working life, evan if retired? PRESSER U.S. MARYLAND 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ding ple HORACE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unkown) | (Ifyesgivawar or detas of service) TAKOMA PARK. MD. LOIS 18. CAUSE OF DEATH [Enter only one cause per tine for (e), (b), end (c) INTÉRVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** Conditions, if eny, which gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1,6/1 19. WAS AUTOPSY CERTIFICATION PERFORMED? 20e, ACC DENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Pert I or Part Is of Item 18.) OR CONTRIBUTING IT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, farm, ; 20f. (City or town) 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED . (County) (State) factory, street, office bldg., atc.) While Not While et work at work 21. I certify that (I) (this haspital) attended the deceased from and that death occured at M, from the causes and on the date stated above; saw the deceased alive on. ATTENDING 22b. DATE MED. SIGNED DIRECTOR PHYS. FUNERAL 22d. ADDRESS BUR.AL. CREMATORY 0.53 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a, REC'D BY VR A15 (4) 15M 7/61

HOSPITA

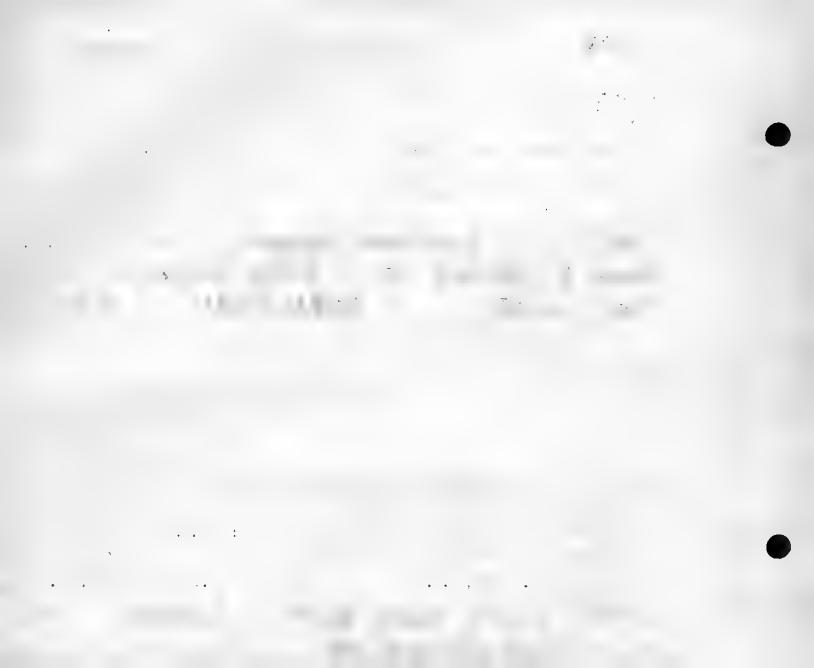
RYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH gest ond 2 after death. certificate be executed within 24 hours after death I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 15 CITY OR TOWN (If outside carparate limits, CITY OR TOWN autside carparate limits, write RURAL and give negrest town) and give nearest tawn) and campletely filled in by the an papers. Powership 72 hour HOSPITAL OR INSTITUTION (If not in hospital give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? NO 🔀 YES NAME OF DATE 4. Year DECEASED OF (Type or point) DEATH AGE (In years IF LINDER 24 HRS S. SEX DATE OF BIRTH IF UNDER 1 YEAR 6 COLOR OR RACE 7. MARRIED NEVER MARRIED (irthday) Months Days Haurs WIDOWED DIVORCED 70b KIND OF BUSINESS OR 12 CITIZEN OF WHAT TO a USDAL OCCUPATION (Give kind of work done lease COUNTRY? the attending physician FATHER'S NAME 14. MOTHER'S MAIDEN NAME 16. SOCIAL SECURITY NO. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? The law requires that the death (Yes, na, apunknown) (If yes give war or dates at service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) signed by physician. DHE TO Conditions, if ony, which gave rise ta immediate cause (a), DUE TO stoting the underlying cause as the the haspital ar attending O FUNERAL DIRECTOR: After this certificate hos been prior ta last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use Health NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20a ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH 40 detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20a PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour om. factory, street, affice bldg., etc.) Not While al wark Page 4 may be retained by shauld be 21. I certify that (1) (this haspital) attended the deceased fram . 196 /, that (I) (we) last 19 to. and that death occurred at 6:30AM, from causes and on the date stated obove sow the deceased olive on, 22b. DATE SIGNED 220. SIGNATURE M.D. PHYS DIRECTOR PHYS. r, page be filed 22c PHYSICIAN'S NAME (Type) director, shauld LOCATION (City or Town) BURIAL, CREMATION, 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY (County) (State) REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 2Sa. REC'D VR A15 (4) DATE 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH and 2 executed within 24 haurs after death the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission o. COUNTY o. STATE b. COUNTY Anne Arundel within 72 hours after Maryland MARYLAND Anne Arundel b CITY OR TOWN (If outside corporate limits. CLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town). write RURAL and give nearest town) filled in by 1 papers. Pa Pasadena Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS Anne Arundel General Hospital 18 Brookview Ave. NO D carban 3 NAME OF 4. DATE Last Day Year DECEASED Type or print) Thomas Edward SHERLOCK DEATH January 19 67 6. COLOR OR RACE 7. MARRIED 9 AGE (In years IF UNDER 1 YEAR NEVER MARRIED 8. DATE OF BIRTH last birthday) Months March 27, 1891 WIDOWED DIVORCED White Male 10g. USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during mass of Marking life, even if retired) COUNTRY? Maryland U. S. requires that the death certifical 13. FATHER'S NAME ar remayal, signed by the attending phy UCKER Address (Yes, no, or unknown) (If yes give wor or dates service) CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause O FUNIRAL DIRECTOR: After this certificate has been lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART 1(a) WAS ALITOPSY PERFORMED? NO YES 🗍 20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) Nat While factory, street, affice bldg, etc.) at work 21. I certify that (I) (this hospital) attended the deceased fram. 19____, that (1) (we) last __. to saw the deceased alive on , and that deoth occurred at o My from causes and on the date stoted above. 22a SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS. 22r PHYSICIAN S 22d ADDRESS NAME (Type) Ray M. Smith. M.D. Hahn ProfBldg., Severna Park, Md. directar, DATE THEREOI NAME OF CEMETERY OR CREMATO (County) (State) 2So. REC'D BY REGISTRAR Meanle



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00175 00177 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY n STATE b. COUNTY Anne Arundel Anne Arundel MARYIAND Marvland b CITY OR TOWN (I outside corporate I mits, write RURAL and give neorest town) C LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park Millersville d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Jumpers Hole Rd. Knollwood Nursing Home, Millersville YES NO S 3. NAME OF DECEASEO (Type or print) Middle 4 DATE Month Doy Year Shriver(Schrieber) DEATH January Sadie (nmi) IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years 7. MARRIED NEVER MARRIED Months Doys lost birthdoy) F. Cau. WIOOWEO 🔽 DIVORCED Dec. 24.1882 12. CITIZEN OF WHAT COUNTRY? 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY Dun Home nelaware Housewife 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Mary E. Mc Graw Thomas Aaron 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Rt.11-Box82 (Yes, no, or unknown) (If yes give wor or dates of service) Mrs. Lottie J. Hovt (daughter)Pasadena Unknown 18. CAUSE OF OEATH (Enter only one couse per line for (o), (b), and (c))
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the llurial-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) DHE TO Conditions, if any, which gave rise to immediate couse (o). DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been Į. 19. WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 14 PERFORMED? NO ξ 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enternature of injury in Part I or Port II of item) OR CONTRIBUTING TRAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 shauld be detache shauld be filed with the State Dept. (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) (State) Not While foctory, street, office bldg , etc.) at work ot work 21. I certify that (i) (this hospital) attended the deceased from April 3, 1965, to Jan. 23, 1967, that (i) (we) last saw the deceased alive on Oct. 8, 1966, and that death occurred at 1/10/1 M, from causes and on the date stated above. 22b. DATE SIGNEO 22o. SIGNATURE MED. DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Ray M. Smith, M. D. Hahn Professional Bldg., Severna Pk., Md 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (Stote) (County) REMOVAL (Specity) Cedar Hill Cometery Md. Jan. 25,1967 Anne Arundel Co. 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Richard V. Singleton Glen Burnie, Md.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY o. STATE b. COUNTY MARYLAND Anne Arundel Mary land. requires that the death certificate be executed within 24 haurs after b CITY OR TOWN (f autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn) i completely filled in by the move carbon papers Page nv event, within 72 haurs af 3yrs. 8mos. Baltimore Crownsville e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 1624 Barnes Street YES NO F Crownsville State Hospital 4 DATE NAME OF Middle Last Day Year DECEASED (Type or pri∰) #25200 Edward J. 19 67 Small DEATH IF UNDER 1 YEAR **B** DATE OF BIRTH AGE (In years IF UNDER 24 HRS s sex 6 COLOR OR RACE NEVER MARRIED 7. MARRIED ast birthday) Days Hours 5/12/99 Male DIVORCED Negro WIDOWED 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work dane 13. BIRTHPLACE (County & State, or foreign country) TOP KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) Cement Finisher INDUSTRY South Carolina USA 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Joseph Small Hattie 16 SOCIAL SECURITY NO 17. INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Yes, no, ar unknown) (If yes give war ar dates af service) None Hospital Records INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) ONSET AND DEATH I-transit PART I. DEATH WAS CAUSED BY Pulmonary Embolism? signed by burial-trans IMMEDIATE CAUSE (o) DUE TO ArterioscleroticCArdio-Vascular Disease Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse the this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO K Chronic Brain Syndrome: Azotomia 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) b 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, TIME OF INJURY Month, Doy, Year factory, street, office bldg , etc.) Not While at work 1/20/, 19_67that (I) (we) lost 21. I certify that (I) (this hospital) attended the deceased from 19 63. to saw the deceased alive on 1/20 1967 , and that death accurred a9: 25 .M, from causes and an the date stated above 22b. DATE SIGNED 220 SIGNATURE 区 M.D. DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S O FUNERAL NAME (Type) Crownsville State Hospital. Md Renedict directar, shauld b 23d. LOCATION (City or Town) County) 23 NAME OF CEMETERY OR CREMATORY 23g BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) BRUTIMORE 25b. REGISTRAR S SIGNATURE 2So REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 [4]



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00178 00176 CERTIFICATE OF DEATH ond 2 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institut on Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel Anne Arundel ician and completely filled in by the fur lease remave carban papers Pages 1 and in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 days Annapolis Pasadena d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) IS RESIDENCE ON A FARM? d STREET ADDRESS 16 Disney Ave., Anne Arundel General Hospital YES NO:XX NAME OF Middle 4 DATE First Lost Month Dov Yeor DECEASED 19 67 SMITH Charles Armond January (Type or pnnt) DEATH IF UNDER 24 HRS S SEX 6 COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 7 MARRIED **NEVER MARRIED** 195 birthdoy) Months Oct. 3, 1894 White Male WIDOWED X DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
Chauffeur INDUSTRY Maryland Produce 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Lowe Smith Laura Virgie Scheminant 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Pasadena Md (Yes, no, or unknown) (If yes give wor or dotes of service) Mrs. Gloria Taylor - 16 Disney Ave., 215-03-8243 ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? CERTIFICATION far use NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (State) 20c. TIME OF INJURY Month, Doy, Year (County) Not While foctory, street, office bldg., etc.) at work ot work **DIRECTOR:** After 11, 19 67, that (1) 206) last Jan. 21. I certify that (1) (this bounded) attended the deceased fram 19 67, and that deoth occurred at M, from causes and on the date stated above saw the deceased alive on___ 77 5:30 22b DATE SIGNED SIGNATURE STAFF PHYS DIRECTOR M.D. directar, page shauld be filed ADDRESS PHYS/CIAN S NAME (Type) 2934 Mountain Road, Pasadena, Md. Arthur Lankford, Jr. 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF (County) 230 BUR AL CREMATION. REMOVAL (Specify) Cedar Hill Cemetery Ritchie Hgwy., A.A.Co., Mi. Jan.14,1967 25o. REC'D BY REGISTRAR George J. Gonce-4001 Ritchie Hgwy. Baltimore 1967



W. PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS CERTIFICATE OF DEATH funeral should. 00179 affer PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) hours a. COUNTY e. STATE b. COUNTY by the and 2 MARYLAND Anne Arundel Maryland AA þ b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) within 24 write RURAL and give nearest town) filled in I Pages 1 affer Glen Burnie Glen Burnie filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) hours d. STREET ADDRESS IS RESIDENCE ON A FARM? completely papers. YES NO North Arundel Hospital Southfield Road 2 3. NAME OF Middle DATE Month Day Year DECEASED OF within (Type or print) DEATH 1967 and cor Edward Whavland January nyder 6. COLOR OR RACE 7. MARRIED THE NEVER MARRIED S. SEX DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. certificate be last birthday) Months Days Hours Min. physician e Male White WIDOWED -DIVORCED 6 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. 12, CITIZEN OF WHAT COUNTRY BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retirad) Dispatcher Coast Tank Lines Baltimore ISA Maryland please Ξ 13. FATHER'S NAME death 14. MOTHER'S MAIDEN NAME attending and Edward W. Snyder. Ruby Then Edna requires that the removal 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT physician, (Yes, no, or unkown) ((Ifyes givewar or dates of sarvice) Dorothy W. Snyder, same as Les INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). has been signed by þ ONSET AND DEATH PART I. DEATH WAS CAUSED BY. CHLMAK cremation, IMMEDIATE CAUSE (a) **burial-transit** DUE TO attending Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying the the hospital or (c) After this certificate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 19. WAS AUTOPSY 80 0 CERTIFICATION PERFORMED? USB prior NO Ö 20a, ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Health OR CONTR BUTING IT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detached be relained by MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (State) ō fectory, street, office bldg., etc.) Hour e.m. While Not While DIRECTOR: A should be det Dept. at work al work 19 p.m. 21. I certify that (I) (this hespital) attended the deceased from...... that (I) (w≠Flast State and that death occurred at A.M. from the causes and on the date stated above saw the deceased alive on..... ПаУ 22a. SIGNATURE 22Ь. DATE SIGNED death. Page 4

TO FUNERAL 3

director, page 3

be filed with the ATTENDING MED STAFF TO HOSPITAL Jan.67 PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Potapsco Ave. Keister. 23d. LOCATION (City, lown or county) (State) 23a. BURIAL, CREMATION, 23b. 23c. NAME OF CEMETERY OR CREMATORY DATE THEREOF REMOVAL (Specify) Baltimore . Burial Jan. 1967 Cedar Hill Cemetery Ma. 254 AREC'D BY REGISTRAR 256 AEGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1301 VR A15 (4). Kirkley Funeral Home, Glen Burnie, Md. 20M 5-63



]	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	00178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00180
HEALTH DEPT.	PLACE OF DEATH O COUNTINE Arundel 2 USUAL RESIDENCE (Where deceosed lived if institution, Residence before odmission) O SHARYLAND ARRYLAND O COUNTINE Arundel
f c y delay is in PM3 Page Department of	b CITY OR TOWN (If autside carparate limits, Grien Way propreneared from) Carparate of the company of the com
_ 2 p = 2 7 1	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) North Arundel Hospital, Glen Burnie, Md. 302 Freetown Road **Gesidence on A FARM?** YES : NO REPORT NOT NOT NOT NOT NOT NOT NOT NOT NOT NO
24 haurs after death. If a note in term 18. Give Pages 1, r's Office along with farmes 1 and 2 with the State De iny event within 72 hours	3 NAME OF OFCEASED (Type or print) Ser brucke Middle Heare OF DEATH 18 19 67
s after 18 Give e alang 2 with it with	S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH 1888 9. AGE (In years last birthday) WIDOWED DIVORCED DIVORCED SYTS Windows Min
1.24 haurs I n Item 18 er's Office ges Tand 2.v	10a US_AL OCCUPATION (G ve kind of work done during prof) 10b KIND OF BUSINESS OR 11, BIRTHP_ACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? 12 COUNTRY? 13 COUNTRY?
	13 FAMER'S NAME 14. MOTHER'S MAIDEN NAME MOTHER'S MAIDEN NAME
xecuted writed in permitted from the first properties of the first properties	(15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Tes, no, or unknown) (If yes give wor or dates of service) Address Security NO 18 Informant 222 Solling
ild be executed rrd "pending" in Chief Medical I transit mermin in, or remaval, c	18. CAUSE OF DEATH (Enter only one couse per line for Let., Dr., and (c).) PART L DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lecture ONSET AND DEATH
should be e se ward "per to the Chief I burial transit mation, ar re	Conditions, if only, which gove) (b)
ficate shang the ded to as a but tremc	rise to immediate couse (a), stoting the underlying cause (c)
This certificate should be executed within cate, writing the word "pending" in pencil be forwarded to the Chief Medical Examine be used as a burial transit permit file agont to burial, cremation, or removal, and in a control of the	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY
4 2 2 2	PERFORMED? 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port II or Port II of tem 18) PRIMARY or CONTRIBUTING CAUSE OF DEATH
MIN the 4 sh ir fil e 3 l	20c TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19 20d INJURY OCCURRED 20e PLACE OF IN, URY (Home, farm, hot While at wark
MEDICAL EXAMIN please execute the I director. Page 4 sh retained far yaur fit. DIMICTOR: Page 31:	21. I certify that I tack charge of the remaine described above, held an Autapsy, Inspection, Inquiry and in my apinion death resulted from, Adviral causes, Accident, Suicide, Hamicide, Undetermined manner
MEDICA olease ex director. etained i portion	ACTUAL CHIEF MEDICAL EXAMINER 22. DATE SIGNED
TO DEPUTY MEDICAL EXAM necessary, please execute the funeral director. Page 4 5 may be retained far your TO LUNERAL DIFFCTOR: Page Health or its designated age	SIGNATURE EXAMINER'S NAME (Type) F Low brack (F. C.
TO DE neces the f the f 5 mo 5 mo TO IUN	230 BURIAL (REMATION, PENOVAL (Specify) 1/23/67 Halls Church Four 22 at 10 cation (City or Town) (County) (State).
VR A15ME (5)	284 FHNERAL DIRECTOR ADDRESS 250 REC D BY REGISTRAR 250 RECUSTRAR'S SIGNATURE DatAN 20 1967 Grances Junger

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 96181 CERTIFICATE OF DEATH executed within 24 haurs after death. filled in by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b_COUNTY o. COUNTY o. STATE Anne Arundel Prince George MARYLAND Maryland c CITY OR TOWN (If autside carparate limits, write RJRAL and give nearest tawn) b CITY OR TOWN (If autside carporate mits, c. LENGTH OF STAY IN 16 write RURAL and a ve negrest tawa) ve carban papers. Pag event, within 72 hours en Burnie Bowle IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS North Arundel Hospital 12711 Brunswick Lane YES 🗍 NOX 3 NAME OF First Middle Last 4. DATE Manth Year DECEASED OF DEATH 67 January Stearn 14 (nmi) (Type or print) S SEX 6. COLOR OR RACE 8 DATE OF BIRTH AGE (In years IF UNDER I YEAR IF UNDER 24 HRS. 7. MARRIED **NEVER MARRIED** last birthday) Months Hours lease remay and in any Female White WIDOWED DIVORCED ctober 29. TOO USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physic dut during most of working life, even if retired) SAARE C COUNTRY? Germany Medical Librarian requires that the death certified 14. MOTHER'S MAIDEN NAME signed by the attending physis burial-transit permit. Then p burial, crematian, ar remaval, Unknown (unknown) Moses 17 INFORMANT dalter 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Stearm (Yes, ng. or unknown) (If yes give wor or dates of service) 12711 Brunswick lane Bowie, Md Husband 100-16-4403 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditions, if any, which gave rise to immediate cause (a), **DUE TO** stating the underlying cause as the prior tal TO FUNERAL DIRECTOR: After this certificate has been lost. WAS AUTOPS'
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION YES -NO [200 ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or tawn) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) 20c TIME OF INJURY Month, Day, Year Hour a.m. factory, street, affice bldg., etc.) Nat While of work at work Poge 4 may be retained by . 1967, that (I) (we) last 21. I certify that (1) (this hospital) attended the deceased from 196 ()_to director, page 3 shauld shauld be filed with the and that death accurred at 1. 20 ML from causes and an the date stated above. saw the deceased alive on 220 SIGNATURE 22b. DATE/SIGNED ATTENDING DIRECTOR M.D. PHYS PHYS. 22d ADDRESS PHYSICIAN'S NAME (Type) 230 BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR/CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Sperify) Baltimore. .Md. Cremator Park Jan.16.1967 pudoh 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66 Glen Burnie, Md. Home Singleton Funeral



- 1 (VI	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
£ 50£	00179 CERTIFICATE OF DEATH 00182
funeral funeral 1 and 2	1. PLACE OF DEATH, a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission as STATE b. COUNTY
irs after by the f Pages 1 urs after	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENCTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
24 hours filled in by appers. Pa	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS et al. S.
executed within 24 hours and completely filled in by remove carbon papers. Pagany event, within 72 hours	3. NAME DF DECEASED (Type or print)
executed within and completely remove carbon any event, with	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. ACE (In years FUNDER 1 YEAR IF UNDER 24 HE last Dirthday) Months Days Hours Min
	10a. USUAL OCCUPATION (Cive kind of work done of the country) 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (Country & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
certificate be nding physiciat	13. FATHER'S NAME 1990 14. MOTHER'S MAIDEN NAME 150 MAY SILL HOLL
ath cer attendir mit, T	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, op unknown) (If yes give war or dates of service)
L OR ATTENDING PHYSICIAN: The law requires that the death certifing be retained by the hospital or attending physician. BIRECTOR: After this certificate has been signed by the attending age 3 should be detached for use as the burial-transit permit. The state Dept. of Health prior to burial, cremation, or removilled with the State Dept.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART II. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART II. 20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CONTRIBUTING COURSED OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) While Not While at work factory, street, office bidg., etc.) 21. I certify that (I) (this hospital) attended the deceased from Attending Med. STAFF 22b. DATE SICNED ATTENDING MED. STAFF
TO HOSPITAL OR Page 4 may be O FUNERAL DISTRICTOR, page Should be filed to	22c. PHYSICIAN'S NAME (Type) SI WING B. MUNESES 22d. ADDRESS 22d. ADDRESS 22d. ADDRESS 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF DEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify)
VR A15 (4)	REMOVAL (Specify) - 9-67 - 10/4 (2053 A 20 C). 24. FÜNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE 14 1967 Recistrar 25b. REGISTRAR'S SIGNATURE
20M 1/65	

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1 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	20180 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT	1. PLACE OF DEATH. a. COUNTY b. COUNTY b. COUNTY c. USUAL RESIDENCE (Where deceased lived, if institution: Residence percent admission) a. STATE b. COUNTY
	H, H.CO MARYLAND MARYLAND
essary, the funeral e 5 may be Department	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1D C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
S III	d. NAME OF HOSPITAL OR INSTITUTION (If not In hospital, give street address) d. STREET ADDRESS!
Page Page ours a	N. HEUNDEL HOSpt. 527 2 nd St. YES NOW
E S SE	3. NAME OF DECEASED A First Middle C Last 4. DATE Month Day Year
PM3.	(Type or print) CHRL F-2)/EDHHAVE DEATH / O 1967
Port of the port o	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. Last birthday) Months Days Hours Min. WIDOWED DIVORCED 1987 1
aga La aga	1Da. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT
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n 18. Life e along pages 1 in any	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME / 1/et
24 hour lem Office File pand	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
mithin 2 pencil i≡ miner's 0 permit. I	(Yes, no, on unknown) (If yes give war or dates of service) T.CARL STEPHANN # 2
pen pen per rem	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).1 PART I, DEATH WAS CAUSED BY:
g" ir Fox ansit	IMMEDIATE CAUSE (8)
e ■xe endin dica ial-tr	Conditions, if any, which (b)
uld Te Executed d "pending" in ef Medical Exar a burial-transit , cremation, or	gave rise to immediate cause (e), stating the DUE TO
shou word Chie as a	Underlying cause lest. (c) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY
ficate shoul the word o the Chied used as a to burial,	PERFORMED? YES NO
EXAMINER: This certificate should be executed within 24 hour after of the certificate, writing the word "pending" in pencil in Item 18. Tive should be forwarded to the Chief Medical Examiner's Office along Mir files. Files. Files. Files. Files. Files. Files.	PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONGIVEN IN PART 1(e) PERFORMED? YES NO PRIMARY OF CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CAUSE OF DEATH.
ER: Thick rate, w forwar forwar 3 short agent,	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, Hour a.m. While Not While Not While 1 factory, street, office bidg., etc.)
the certificed should be ir files. CTOR: Page designated	21. certify that took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
CXA the ce shoul files. OR:	death resulted from Natural causes , Accident , Suicide , Homicide , Undetermined manner
the the the second seco	ACTUAL CHIEF MEDICAL EXAMINER 22. DATE SIGNED
ry MEDIU execute Page I for you NAL DIRE	DEPUTY MEDICAL EXAMINER
o DEPUTY please ex director. retained of FUNERA of Health	RAMM (Type) Address (Street, city, town, or county) (State)
TO DEPUTY MEDIC. EXP please execute the c director. Page 4 shou retained for your files TO FUNERAL DIRECTOR: of Health or its design	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town of county) (State) BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY HUNAPOLIS ADDRESS 258. REC'D BY REGISTRAR'S SIGNATURE
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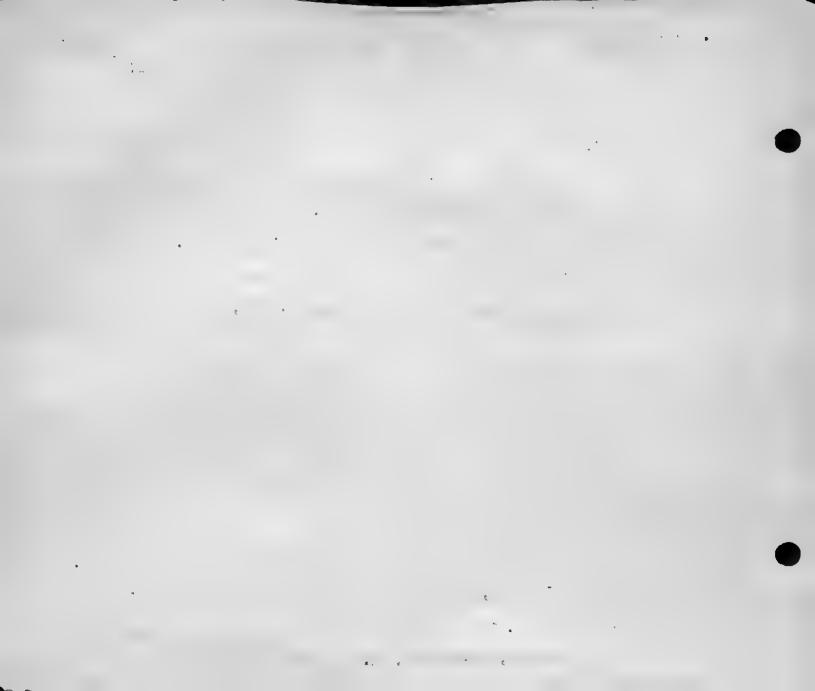
	1	MARYLAND STATE DEPARTMENT OF HEALTH AR DRISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
_{स्टिक्}	E2 5	The project of Statistical Research and Records, 301 W. Preston Street, Baltimore 1, Maryland 10-11/Film#G3841/16/67pc CERTIFICATE OF DEATH 00184	
24 hours after death	funeral 1 and 2 r death.	1. PLACE OF OEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admits	sien
fter	the fes 1	MARYLAND MARYLAND MARYLAND MARYLAND	1
S 2	n by Pag	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARRIVATOR OF TOWN (If outside corporate limits, write RURAL and give nearest town)	JWI
를 ⁴ 등	led in pers. 72 h	d. NAME OF HOSPITAL DR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDE	NCE M?
	_ 다'는	TIC WELLS ST. 910 WELLS ST YES NO	v
with	physician and completely filled in by the far please remove carbon papers. Pages 1 val. and in any event, within 72 hours after	3. NAME OF DECEASED (Type or print) ANNIE REBECCA WOOD STEVENS DEATH / 2 196	7
uted	ove o	5. SEX 6. COLDR DR RACE 7. MARRIED NEVER MARRIED 8. DATE DF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 Hours 1	HRS
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ficate	oval play	13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME	
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that the death certificate be executed within	ding physician. been signed by the attending ph the burial-transit permit. Then or to burial, cremation, or removal	(Yes, no, or unknown) (If yes give war or dates of service) - MASIKATHER INSTITUTE THE PHANT OF 2	
the d	y the Isit p	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: ONSET AND OEA ONSET AND OEA	EN
that	ician ped to I-tran II, cre	IMMEDIATE CAUSE (a) Colored as clear to sufficiency	Z£:[
lres t	phys sign buria buria	Conditions, if any, which (b)	
The law requires	or attending physician. sate has been signed by use as the burial-tran salth prior to burial, cre	gave rise to Immediate cause (a), stating the OUE TO underlying cause last. (c)	
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		Kheirmatord artheritis YES NO	K
CIAN		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORME YES NO 20a. ACCIOENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. OESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part II of Item 18.)	
PHYSI	this this leta	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State	e)
2	d by the		
TEND	retained Scrok: Af Schould I with the S	21. I certify that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, to 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, that (I) (this hospital) attended the deceased from 6 7, 1967, the deceased from 6 7, 196	las
R AT	RECT 3 S S S S S S S S S S S S S S S S S S S	22a. SURRE 2 2.0 DATE SIGNEO	
AL 0	nay be	22c. PHYSICIAN'S NAME (Type) OT 11 3 67	
HOSPITAL	Page 4 may be retained by to FUNERAL DIRECTOR: After director, page 3 should be calouid be filed with the State	NAME (Type) Kichard I. Hochman MD 59 Franklus J. Annapolis, hid	
E 2	Pag O File dire shot	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERS OR CREMATORY 23d. LOCATION (City, town or county) (State)
•	0.	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR' 25b. REGISTRAR'S SIGNATURE	1
	R AIS (4)	VOHN M. TAKER SONS HUNAROLIS MD. LOATE JAN 5. 1967 Blowles Judy	L
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2	1 (8 4	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	[V]		10183 CERTIFICATE OF DEATH
0	funeral funeral r death.	1.	PLACE DF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Beddence before admission) a. STATE b. COUNTY
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			MOLLWOOD. MINNON. LOCA SONO > 18 I YES INOTO
	withi	3.	NAME OF DECEASED First Middle Last 4. DATE Month Day Year DECEASED (1) ACC 1 N 1 A M 1 Sellevent DEATH (-13-67, 19
	executed within and completely fremove carbon par any event, within	5.	SEX 6. COLONFOR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.
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	g skig	I	Housevel Home Elfrens W. Va A Cl. S.
	tificat ig phi if phi indval,	13	3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 14. MOTHER'S MAIDEN NAME
	The law requires that the death certificate or attending physician. cate has been signed by the attending physic ruse as the burial-transit permit. Then preeath prior to burial, cremation, or removal-al-	T T	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (es, no, or junkown) (1f yes give waper datus of service)
	deat he at perm tion,		18. CAUSE OF DEATH [Enter only one cause let light for (a), (b), and (c).]
	law requires that the deat thending physician. has been signed by the at as the burial-transit permitor to burial, cremation,		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)
	es tha hysici signer rial-ti		Conditions, If any, which) DUE TO GEN-AVT ASSELLED
	ling p ling p been the bu		gave rise to immediate cause (a), stating the DUE TO
	law rattend has le as le as l	N	underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(2) [19. WAS AUTOPSY]
	The ficate or use or use	CERTIFICATION	PERFORMED? YES NO NO
	OR ATTENDING PHYSICIAN: The law requires that the retained by the hospital or attending physician. DIRECTOR: After this certificate has been signed by ze 3 should be detached for use as the burial-transed with the State Dept. of Health prior to burial, created with the State Dept.	CERT	206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	PHYS the h this detac	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, Hour a.m. While Not While
	DING ed by After d be e Stat	¥	p.m. 19 at work at work 21. I certify that (!) (this hospital) attended the deceased from 1960, 19, to 19, that (!) (we) last
	ATTENDING PH retained by th ECTOR: After th 3 should be de with the State I		saw the deceased alive on 1-11-67 19 and that death occurred at 8 M, from the causes and on the date stated above.
	L OR ATTENI y be retaine DIRECTOR: age 3 should		22a. SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR PHYS. 22b. DATE SIGNED 67
	TO HOSPITAL O Page 4 may b TO FUNERAL DI director, page should be file		PAME (TYPE) Robert R. HAHW. P.O. Box 73 Several Ph
	Page Page TO FUI direc	23	1a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
	an	2	DDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
	VR A15 (4) 20M 1/65	2	LOBERTS, BARRANCO TRIBLE JAN 16 1967 geleviles Judge
			ENKENS, ISHERINGO



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		o, state b. county Maryland	1.4
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	write RURAL and give nearest town)		
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		1 12 11 11 11 11	ON A
3.	Box 141, North Ferry Point Road	Box 141, North Ferry Point	Road YES T
	DECEASED	OF	
_	MTTTTAM 9036BU	Teal DEATH Jan	mary 13, 196
٥.	6. COLOR OR RACE 7. MARRIED NEVER MARRIED	B. DATE OF BIRTH 9. AGE (In yeers IF lest birthdey)	UNDER 1 YEAR OF UNDER
	Male White WIDOWED DIVORCED	Sept. 13. 1897 69 yrs. 1	1 Days 110015
	10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	RY 11. BIRTHPLACE (County & State, or foreign country)	12, CITIZEN OF WHAT C
	Chauffeur Retired	Baltimore . Md.	USA
i	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	MARCA
	Frank Teal	A 71.3	
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	Annie Hines	
	(Yes, no, or unkown) (Ifyes givewer or detes of service)		
	IB. CAUSE OF DEATH [Enter only one couse per line for (e), (b), and (c).]	Nanie L. Teal, same as 2	I INTERNAL CET
	BARTA REATH WAS CAUSED BY		ONSET AND D
	IMMEDIATE CAUSE (a)	ng	_ 2 mon
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	Conditions, if any, which (b)		
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		OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN	IN PART I(e) 19. WAS A
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	200. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURE	ED. (Enter nature of injury in Pert) or Pert II of item 18.)	
	OR CONTRIBUTING [] CAUSE OF DEATH U (IF EITHER, NOTIFY MEDICAL EXAMINER)	Investment At milets to Late 5 at 1 Att or at man had	
		ACE OF INJURY (Home, ferm. ; 20f. (City or town)	(County)
ĺ	Hour e.m., Whife Not Whife	ctory, street, office bldg , etc.)	(awaiii)
	7 1 2 2		/ 5-
	21. I certify that (I) (this hospital) attended the deceased from	NOV. 20, 19/6, to JAN 13	, 1962 C., that (I) (
	saw the deceased alive on	t death occurred and 20 M, from the causes and	on the date stated
	220. SIGNATURE		22b
	J. Brader Anula	M.D. PHYS. DIRECTOR PHYS.	14 Jan. 196'
	22c. PHYSICIAN'S	22d. ADDRESS	1.3
	NAME (Type) Brady Smith M. D.	Riviera Beach, Pasadena	Maryland
	23e. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY		
	REMOVAL (Specify)		
-	Burial 16 Jan. 1967 Western 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS		
		JAN 10 196/ X	laries Juntar
	Kirkley Funeral Home, Glem Burnie, Md.	DATE	// 0



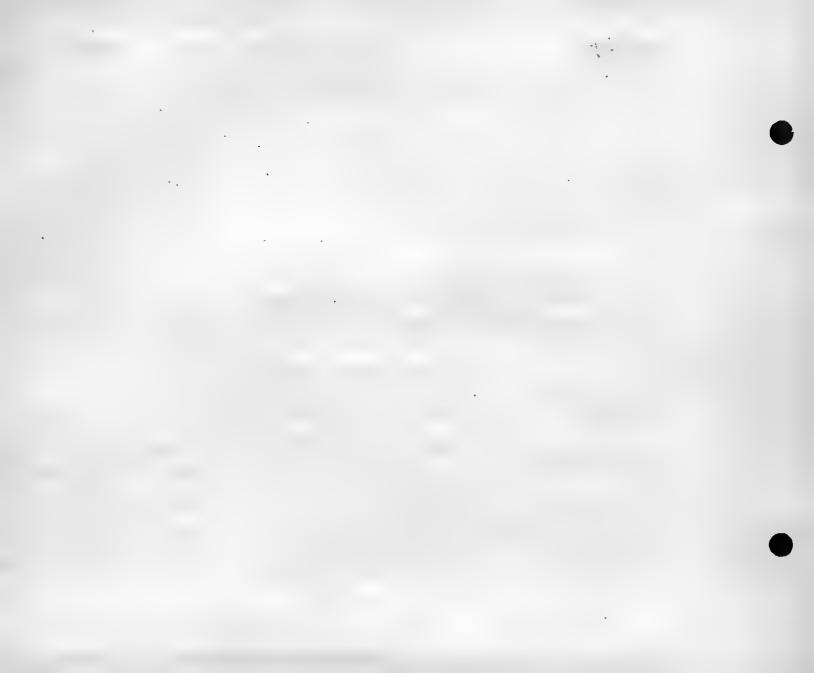
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00185 CERTIFICATE OF DEATH 00187 requires that the death certificate be executed within 24 hours ofter death **Gerdeath** and campletely filled in by the funeral remove carbon papers. Pages 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY n. STATE h. COUNTY Anne Arundel MARYLAND Maryland Anne Arundel CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? event, within 72 h 305 Edgemere Drive NO F YES Anne Arundel General Hospital 4 DATE 3 NAME OF Micidile Month Lost Doy Year DECEASED OSEPH TRAYNOR DEATHJanuary 19 67 (Type or print) IF JNDER 1 YEAR IF UNDER 24 HRS. 9 AGE (n years S. SEX 6 COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED lost birthdoy) Months Hours QUA White WIDOWED DIVORCED January 1, 1967 Male 10o JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) gleose INDUSTRY COUNTRY? Maryland 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? or reg (Yes, no, or unknown) (If yes give wor or dates of service burial, cremation, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per (a), (b), and (c). signed by the barral-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been the lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TELMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? CERTIFICATION Heolth NO the hospital or ģ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING (detached for the Dept. of the OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) Not While of work of work 21. I certify that (1) (this hospital) attended the deceased from M from couses and an the date stated above. director, page 3 should should be filed with tile? saw the dereosed alive on and that death occurred at 22b DATE SIGNED SIGNAT ATTENDING M.D. DIRECTOR PHYS. PHYS 22d ADDRESS 22c. PHYSICIAN'S South River Ned. Ctr., Edgewater, Md. NAME (Type) Rivera Antonio 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (State) 230 BURIAL, CREMATION 23b DATE THEREOI (County) LLCREST 5 R1 WIIAPOLIS 2Sb REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 JAN 19 6



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00186 CERTIFICATE OF DEATH 00188 ician and campletely filled in by the funeral lease remave carban papers. Pages 1 and 2 and in any event, within 72 hours after death requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE **6 COUNTY** MARYLAND b. CITY OR TOWN (If outside corporate imits c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) write RURAL and give nearest tawn) BILLOOKIAN d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM? EDGEVALE CROWNSVIVI 3 NAME OF M-ddle Year Lost DECEASED (Type or print) OF DEATH VO SLER - 19 IF UNDER 1 YEAR S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years IF UNDER 24 HRS bi(thdoy) Months Davs Hours WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY physician WISCONSIN U.S.A Serviceman 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME signed by the attending physi burial-transit permit. Then pl burial, cremation, ar removal, NOSLER 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) Mrs. Ethel Vosler-23h Edgevale Rd. Yes and WWI INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per ne for (a), (b), and (c)) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) PRONCHOPNEUMONIA Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the lost PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPS'
PERFORMED? be detached for use State Dept, of Health YES 🗌 NO 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stole) TIME OF INJURY Month, Day, Year foctory, street, office bldg , etc.) Not While ot work 21. I certify that (I) (this haspital) attended the deceased fram 12-7 19 6 that (I) (we) lost director, page 3 shauld shauld be filed with the PM, fram causes and an the date stated above , and that death occurred at 🔃 saw the deceased alive an 19 (22b. DATE SIGNED 22o. SIGNATURE MED DIRECTOR & M.D. PHYS 220 ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) (Stote) 230 BURIAL, CREMATION REMOVAL (Specify)
Burial 2-1-1967 Cedar Hill Cemetery Ritchie Hgwy., A.A.Co. Md. 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATUR 24 FUNERAL DIRECTOR 196 DATE FFB George J. Gonce-4001 Ritchie Hgwy., Baltimore



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH cate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) o. COUNTY COUNTY MARYLAND r LENGTH OF STAY IN 15 b CITY OR TOWN (If outside corparate simils, c CITY OR autside corporate limits, write RURAL and give negrest town) d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. SPREET ADDRESS and campletely filled in ON A FARM? NO E YES NAME OF Middle DATE Month Dov Year First DECEASED MAMURIKA 196 DEATH and in any event, (Type or print) COL AGE (I'm years IF LONDER 1 YEAR IE UNDER 24 HRS S SEX 6 COLOR OF RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH lost birthday) Months Days Hours V DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done COUNTRY? physician (please during most of warking lite; even if retiged INDUSTRY 13. FATHER'S NAME MOTHER'S MAIDEN NAME or remayal, attending p permit. The INFORMANT Address requires that the death (Yes, no, or unknown) (If yes give war or dotes of service signed by the after burial-transit permit burial, cremation, o INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a) ONSET AND DEATH PART , DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Canditions, if any, which gave rise to immediate cause (a). DUE TO stoting the underlying cause O FUNERAL DIRECTOR: After this certificate has been detached far use as the te Dept, af Health priar ta last WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO YES 20g. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of moury in Part I or Part II of Item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) with the State Dept. 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour om. factory, street, affice bldg , etc.) Not While at wark shauld be 1967, that (I) (we) last 2]. I certify that (1) (this hospital) attended the deceased fram July and that death accurred at 8 120 M, fram causes and an the date stated above. saw the deceased alive on. 220 SIGNATURE 22b. DATE SIGNED DIRECTOR directar, page 3 should be filed v M.D. PHYS PHYS 22d _ADDRESS 5 PHYSICIAN'S NAME (Type) direct 23a BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) REMOVAL (Specify) Lorsville Cemeterr Carroll ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4), 20 M 1/66 Box 241 Sykesville.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. and 2 death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Pages 1, urs after after ANNE ARUNDEL ANNE ARUNDEL MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Write RURAL and give nearest town) hours ANNA POLIS 39 DAYS ANNAPOLIS papers. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Filled 6. IS RESIDENCE ON A FARM? d. STREET ADORESS event, within 72 No C NAVAL HOSPITAL 504 DEWEY YES DRIVE etely carbon 3. NAME OF First Middle Last 4. OATE Mon th Day Year **OECEASED** OF Owen WILLIAMS JAN RICHARD 8 68 (Type or print) **OEATH** 19 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. етоме 7. MARRIEO NEVER MARRIEO last birthday) Months Davs Hours MALE CAUC WIOOWED X 18 MARCH 1879 87 DIVORCEO I County & State, or foreign country) 10a. USUAL OCCUPATION (Give kind of work done) Ξ. 10b. KINO OF BUSINESS OR COUNTRYZUSA 12. CITIZEN OF WHAT ician during most of working life, even if retired) INOUSTRY eas NAVAL OFFICER RET U. S. NAVY CAENARVANSHIRE Per P requires that the death certificate 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending ph гетома SARAH FOOD WILLIAM EVION WILLIAMS ed by the attend transit permit. cramation, or ru 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT MOHS DEWEY DR. (Yes, no, or unknwn) . (If yes give war or dates of service) YES 1895-1930 DOROTHY K. WILLIAMS ANNA. MD. 220-111-0699 18. CAUSE OF GEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND CEATH -transi PART I. DEATH WAS CAUSED BY: CONGESTIVE PILLIRE been signed the burial-transtrantor to burial, cra IMMEDIATE CAUSE (a)_ **OUE TO** Conditions, If any, which RTERIOSCLERON gave rise to Immediate DUE TO cause (a), stating the as th prior 1 underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health PERFORMEO? YES X NO T 20a, ACCIDENT WAS UNDERLYING I OESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part II of Item 18.) r this cert detached OR CONTRIBUTING CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) thould be de factory, street, office bldg., etc.) Hour a.m. Not While at work While p.m. at work 1966 NON to 8 JAN 1967_ that (i) (we) last 21. I certify that (I) (this hospital) attended the deceased from. and that death occurred at 2074M, from the causes and on the date stated above. DIRECTOR 8 JAN saw the deceased alive on 22a. SIGNATURE 22b. OATE SIGNED MEO. page STAFF JAN 1967 DIRECTOR X M.O. PHYS. PHYSICIAN'S FUNERAL AODRESS 22c. 22d. should be NAME (Type) director, JOHNSON USNR NAVAL HOSPITAL. ANNAPOLIS. MARYLAND BURIAL, CREMATION, 23a. 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d/ LOCATION (City, town or county) (State) 2 NERAL DIRECTO REC'D BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY a. STATE by the fa Pages 1 ars after after ANNE ARUNDEL ANNE ARUNDEL MARYLAND MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) etely filled in by 1 bon papers. Page within 72 hours a write RURAL and give nearest town) hours ANNAPOLIS MARYLAND 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12 MARYLAND AVE. ANNAPOLIS. MD e. IS RESIDENCE d. STREET ACCRESS ON A FARM? NAVAL HOSPITAL NO I 12 MARYLAND AVE. YES L within completely carbon NAME OF First Middle Last OATE Month 4. Year DECEASED OF event. 1967 JAN. (Type or print) EMILY H. WINTERS DEATH executed emove 6. COLOR OR RACE OATE OF BIRTH AGE (In years IFUNOER 1 YEAR IF UNDER 24 HRS. last birthday) Months I Days Hours I Min. 7. MARRIEO NEVER MARRIEO Months Days Hours pug FEMALE CAUC. WIOOWEO T DIVORCEO [JAN. 17. 1891 10a. USUAL OCCUPATION (Give kind of work done) 10b. KINO OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT pe during most of working life, even if retired) INDUSTRY COUNTRY? NONE USA BELLEFONTE PA. HOUSEWIEE certificate DAG 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME attending ph ermit. Then remova MARION HUGH BASSETT FRANK PECK BASSETT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 3757 PEACHTREEpermit. 0 death (Yes, no, or unkown) (If yes give war or dates of service) USN/RET DUNWOODY RD. cremation, GAPT HUGH WINTERS NO the been signed by the street to burial, cremati 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), 1 A FRANTA GA. INTERVAL BETWEEN that the **DNSET AND OEATH** PART I. OEATH WAS CAUSED BY: physician. ENAI FAILURE IMMEDIATE CAUSE (a) **OUE TO** FAILURE HEART Cenditions, if any, which CONO-ESTIVE rise to immediate hospital or attending **OUE TO** cause (a), stating the underlying cause last. has 35 (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use Health PERFORMEO? certificate YES D NO [PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING I 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) detached f OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) this MEDICAL 20c. TIME OF INJURY Month, Cay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) After tild be de e State i Hour a.m. factory, street, office bldg., etc.) While Not While at work ATTENDING p.m. at work retained DIRECTOR: A age 3 should led with the to 8 JAN 26 DEC 1900 21. I certify that (I) (this hospital) attended the deceased from JAN and that death occurred a 0607AM, from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED 68 page ATTENDING MEO. 8 JAN 67 OIRECTOR __ PHYS. M.O. HOSPITAL FUNERAL PHYSICIAN'S 22d. AOORESS director, p NAWE (TYJUHNSON USNH ANNAPOLIS. MD. BURIAL CREMATION, REMOVAL (Epecify) 23c. NAME OF CEMETERY OR CREMATORY 23a. 23b. DATE THEREOF LOCATION (City, town or county) (State) 2 REC'O BY REGISTRAR FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE 0 Chari VR A15 (4) 20M 1/65

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O HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the Page 4 may be retained by the hospital or attending physician.	TO FUNERAL DIRECTOR. After this certificate has be director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior		saw the deci 22a. SIGNATUR	by Ey P.	Suh	19 67.		ATTENDING PHYS. 22d. ADDRESS	950, toM, from MED. DIRECTOR enning	the causes a	and on the	SIGNED 6	
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